



**PREVENTATIVE MEDICATION & PRIOR AUTHORIZATION REQUEST FORM**

**\*\*\* Must be completed in Full to process \*\*\***

**Must Include Laboratory Results, Physical exam findings and Associated Risk Factors as Applicable**

**Patient Information**

PATIENT NAME: (LAST, FIRST)	DOB:(mm/dd/yyyy)	AGE:	SEX:
PATIENT PHONE:	HEIGHT:	WEIGHT:	

**Physician Information:**

PRESCRIBERS NAME:	SPECIALTY:		
CONTACT PERSON:	PHONE:	FAX:	

**Medication Request:**

DIAGNOSIS/INDICATION:				
DRUG NAME & STRENGTH:	SIG:	QTY:	DAYS SUPPLY:	REFILLS (# or N/A)
NEW THERAPY YES      NO	EXPECTED DURATION OF THERAPY			
	LAST EVALUATION DATE (mm/dd/yyyy)	NEXT APPOINTMENT DATE(mm/dd/yyyy)		

**Medical History:**

<b>Include Laboratory Results, Physical exam findings and Associated Risk Factors as applicable: (ex: A1c for diabetes, lipid and liver panel for cholesterol, viral loads and CD4 counts for HIV), attach additional information if needed.</b>		
Is the patient on other prescription medications <u>currently</u> to treat this diagnosis?	<b>Yes /</b>	<b>No</b>
* If yes, please identify: Medication, Strength, Directions		
Is the patient on other non-prescription therapies <u>currently</u> to treat this diagnosis?	<b>Yes /</b>	<b>No</b>
* If yes, please identify: Therapy		
Have any other prescription medications been <u>tried in the past</u> for this diagnosis?	<b>Yes /</b>	<b>No</b>
* If yes, please identify: Medication, Strength, Directions, Reason Discontinued, Date Discontinued		
Have any other non-prescription therapies been <u>tried in the past</u> for this diagnosis?	<b>Yes /</b>	<b>No</b>
* If yes, please identify: Therapy		
Does this disease/diagnosis/condition have staging or an assessment of severity? (Ex: % of body covered for psoriasis)	<b>Yes /</b>	<b>No</b>
* If yes, please indicate the extent/severity of the disease/condition		