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:

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. ☐

Is the patient on other prescription medications currently to treat this diagnosis? ☐ **Yes /** ☐ **No**
* If yes, please identify: Medication, Strength, Directions

Is the patient on other non-prescription therapies currently to treat this diagnosis? ☐ **Yes /** ☐ **No**
* If yes, please identify: Therapy

Have any other prescription medications been tried in the past for this diagnosis? ☐ **Yes /** ☐ **No**
* If yes, please identify: Medication, Strength, Directions, Reason Discontinued, Date Discontinued

Have any other non-prescription therapies been tried in the past for this diagnosis? ☐ **Yes /** ☐ **No**
* If yes, please identify: Therapy

Does this disease/diagnosis/condition have staging or an assessment of severity? (Ex: % of body covered for psoriasis) ☐ **Yes /** ☐ **No**
* If yes, please indicate the extent/severity of the disease/condition