Prior Authorization Request Form: Medications

Please type or print neatly. Incomplete and illegible forms will delay processing.

I. Provider Information

Prescriber name	NPI #
Prescriber specialty	Phone
Prescriber address	
Office contact name	Fax
Pharmacy name	Pharmacy phone

II. Member Information

Member name	Today's date
Member plan ID #	Date of birth
Drug allergies	
Plan name and fax for form submission	

III. Drug Information (one drug per request form)

Drug name	Drug strength	Dosage form	Dosage interval	Quantity per day
Diagnosis relevant to this request				ICD-9 code
Expected length of therapy				Number of refills

IV. Drug History for this Diagnosis

A. Is the prescription for a drug to be administered in the office or for the member to take at home? office home

B. Is the member currently treated on this drug? Yes: how long? _____ [go to item C] No [skip items C and D; go to item E]

C. Is this request for continuation of a previous approval? Yes [go to item D] No [skip item D; go to item E]

D. Has strength, dosage or quantity required per day increased or decreased?

Yes [go to item E] No [skip item E; indicate rationale in Section V and submit form]

E. Please indicate previous treatments and outcomes with other medications below.

Drug name	Strength	Directions	Dates of therapy	Reason for failure or discontinuation

V. Rationale for Request and Pertinent Clinical Information (attach additional sheets if more space is needed)

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.

Prescriber/Authorized Representative signature	Date

Plan Fax Numbers

EHO – 254-774-8155