Part B Drug Prior Authorization Request Form

Certain requests for coverage require review with the prescribing physician.

PLEASE

- Complete this form and call or fax the number listed under the logo.
- Note any information left blank or illegible may delay the review process.
- Use one form per prior authorization request.

allwell. FROM mhs health wisconsin

Phone: 1-844-982-1578
Fax: 1-844-960-1787

I. MEMBER INFORMATION		II. PRESCRIBER INFORMATION	
Name:		Name:	
ID Number:		Specialty:	
Group Number:		NPI/DEA Number:	
Date of Birth:		Facility Name:	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Phone Number:		Phone Number:	
		Fax Number:	

III. MEDICATION REQUESTED	
Drug Name:	
Directions/SIG:	
Quantity:	
J-Code (if applicable):	

IV. ADDITIONAL CLINICAL INFORMATION	
ICD-10 Code:	
Diagnosis:	
Is the medication being requested for use in an ongoing investigational trial? ❑ YES ❑ NO	

V. MEDICATION HISTORY (for this diagnosis)

List therapeutic alternatives previously used with start/end dates and outcomes:

	Drug Name, Strength, and Dosage	Dates of Therapy	Reason for Discontinuation
1			
2			
3			

VI. PERTINENT CLINICAL INFORMATION

Clinical information is required to make a determination. Please attach pertinent medical history and/or information for this member that may support approval. Any additional notes can be included in this space:

☐ **STANDARD REVIEW**

☐ **EXPEDITED REVIEW** By signing below, I certify that applying the standard 14-day timeframe could seriously jeopardize the member's health, life or ability to regain maximum function.

PRESCRIBER SIGNATURE **DATE**