# Part B Drug Prior Authorization Request Form

Certain requests for coverage require review with the prescribing physician.

allwell. FROM mhs health wisconsin

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.

**Phone: 1-877-935-8024**
**Fax: 1-877-687-1183**

| 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**