

# 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.

**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**