

Authorization Request Form

PLEASE FAX THIS REQUEST FORM TO 1-855-875-7443 (toll-free)

The prescriber must complete this form in full to avoid processing delay. Please attach any information that should be considered with this request.

Patient Information

Patient Name:

Date of Birth:

Member ID #:

Plan Name:

Plan Number:

Prescriber Information

Prescriber's Name:

DEA/Licensing Number:

NPI Number:

Office Phone:

Fax:

Clinic Name:

Contact Name:

Address:

City:

State:

Zip:

Pharmacy:

Phone:

Fax:

Drug Information

Reason for Authorization Request (Leave blank if unknown)

Prior Authorization for clinical criteria

Step Therapy

Quantity Limit override

Non-formulary medication

Requested Drug Name and Strength:

Quantity:

ICD-9

Directions:

Start Date of Therapy:

Diagnosis:

Previous Drugs Tried and Reason for Past Failures: (OTC products may be included)

Trial #1 - Drug Name:

Dosage:

Start Date:

Date Discontinued:

Reason for Discontinuation:

Trial #2 - Drug Name:

Dosage:

Start Date:

Date Discontinued:

Reason for Discontinuation:

Trial #3 - Drug Name:

Dosage:

Start Date:

Date Discontinued:

Reason for Discontinuation:

List any contra-indications to formulary alternative or generic medications:

Significant lab values:

Quantity Limit Exception: (please provide dosing schedule and tapering information):

Requesting Provider's Signature

Date

PLEASE FAX THIS REQUEST FORM TO CLEARSCRIPT AT 1-855-875-7443

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