

MIDAP REQUEST FOR PRIOR AUTHORIZATION

Prescribing Physician:

Name: _____

First Last

Direct Phone #: (____) _____

Fax #: (____) _____

Physician specialty: _____

Patient:

Name: _____

First Last

ID#: _____

Phone #: _____ Client: _____

Birth Date: ____ - ____ - _____ Sex: Female Male

Name and title of person completing form (please print): _____

Drug name: Strength: Administration Schedule: Length of Therapy: Quantity Requested:

a) _____

b) _____

c) _____

Has patient been on this drug and, if yes, for how long at this dosage? _____

Patient's diagnosis requiring the use of this medication: _____

1. Previous history of a medical condition, allergies or other pertinent medical information that necessitates the use of this medication:

2. Has the patient been seen by any other provider for this condition? Yes No
If so, what was the prescriber's specialty? _____

3. Previous non-prior authorized and prior authorized medications tried and failed for this condition:

Name of medication	Reason for failure	Date:
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

4. Pertinent laboratory test or procedure: (if applicable)

Procedure:	Findings:	Date:
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

5. Other Information: _____

Fax Request to: ScriptGuideRX @ 313-499-3201

<p>For ScriptGuideRX use only</p> <p>Date received:</p> <p>Date completed:</p>

<p>Decision (all authorizations are pending valid eligibility):</p>
