REQUEST FOR PRIOR AUTHORIZATION

Prescribing Physician:	
Name (First, Last)	
Direct Phone #	
Fax #	
Physician specialty	

Patient:	
Name (First, Last)	
ID #	
Phone #	Client
Birth Date ___/___/_____	Sex ☐M ☐F

Name and title of person completing form (please print)			
Drug name:	Strength:	Length of Therapy:	Quantity Requested:
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? If so, what was the prescriber's specialty?		☐Yes ☐No	
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:			

Physician's Signature _____ **Date** ___/___/_____

Fax Request to: SGRX @ 313-264-0985

For ScriptGuideRX use only)

Date faxed: ___/___/_____ Date received: ___/___/_____ Date completed: ___/___/_____	Decision (all authorizations are pending valid eligibility)

Date:

Attention:

Fax:

Re:

DOB:

Medication:

We have received the prior authorization request for the above patient. However, we need further information to process this request. Please submit documentation such as labs, A1C, if applicable, and any other information pertinent to patient's diagnosis. Please also include any medication tried/failed in this drug class and/or for this diagnosis; please resubmit request with all supportive documentation.

If you have any questions feel free to contact us @ 1-855-855-7479

Please fax to: 313-264-0985

Thanks in advance
Prior Authorization Desk
SGRX

Submitting the prior authorization without these requested, supportive documents will stagnate the prior authorization process. The request will be considered incomplete and will NOT be forwarded to clinical for review and approval until all necessary documentation is received.

15400 E. Jefferson Avenue • Grosse Pointe Park • MI • 48230 • 855-855-SGRX, ext 207
www.SGRXhealth.com