

REQUEST FOR PRIOR AUTHORIZATION

Prescribing Physician:

Name:

First

Last

Patient:

Name:

First

Last

Direct Phone #: () -

ID#: _____

Fax #: () -

Phone #: () - Client: ****SELECT ONE****

Physician specialty: _____

Birth Date: - - Sex: ****SELECT ONE****

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

Drug name: Strength: Administration Schedule: 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? ☐ 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: _____

Physician's Signature: (X) _____ Date: _____

Fax Request to: ScriptGuideRX @ 313-499-3201

(For ScriptGuideRX use only)

Date faxed: 9/21/2016

Date received: / /

Date completed: / /

Decision (all authorizations are pending valid eligibility)