

**SCRIPTGUIDERX REQUEST FOR PRIOR AUTHORIZATION
STEP THERAPY VALTREX**

Prescribing Physician:

Patient:

Name: _____

Name: _____

First Last

First Last

Direct Phone #: (_ _) _____

ID#: _____

Fax #: (_ _) _____

Phone #: _____ Group: _____

Physician specialty: _____

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) _____

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:
_____	_____	__/__/__
_____	_____	__/__/__
_____	_____	__/__/__

**** Valtrex - please note if any of the following first line agents have been tried such as :**

Acyclovir

***** Please include chart notes if this has been tried.**

Fax Request to: ScriptGuideRX @ 313-264-0985

Date Received:
Date Completed:

Decision (all authorizations are pending valid eligibility):
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