PRIOR AUTHORIZATION GENERAL REQUEST FORM

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

Patient:	
Name (First, Last)	
ID #	Sex (at birth): ❑ M ❑ F
Phone #	Client
Birth Date: ___/___/___	Age

Name and title of person completing form (please print):		
Drug name:	Dose/Strength:	Frequency:
Patient's diagnosis & ICD code requiring the use of this medication:		
Has patient been on this drug? ❑Yes ❑No If yes, for how long: _____		
Has the patient been seen by any other provider for this condition? ❑Yes ❑No		

What are the previous medications that were tried and failed in the past for this diagnosis:		
Drug name	Reason for failure	Dates
		From ___/___/___ To ___/___/___
		From ___/___/___ To ___/___/___
		From ___/___/___ To ___/___/___
		From ___/___/___ To ___/___/___
		From ___/___/___ To ___/___/___

Please indicate pertinent laboratory tests or procedures for this diagnosis:		
Procedure/Lab:	Findings:	Date:

Physician's Name (print): _____ **Title:** _____

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

Fax PA request form AND Supporting Documentation to: SGRX @ 313-264-0985