REQUEST FOR PRIOR AUTHORIZATION

Prescribing Physician:	
Name (First, Last)	
Physician specialty	
Phone #	Fax #
Facility Name	Facility Phone #
Name and title of person completing form (please print)	
Administration Type: □ Self-administered □ Physician office □ Hospital □ Home Health Care □ Infusion Center	
Fulfillment Type: □ Buy and Bill □ White Bag – medication received directly from a Specialty Pharmacy □ Brown Bag – medication received from a patient	

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

Medication:	
Drug name and strength:	
J-Code	Quantity Requested:
Length of Therapy:	Frequency of Administration:
CPT Codes associated with administration:	

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. Attach supporting documents such as chart notes and laboratory findings to the request. Provide other important information/rationale:		

Supportive documentation such as chart notes and laboratory findings must be submitted for the request to be reviewed.

Physician's Signature_____ **Date** __/__/____

Fax Request to: SGRX @ 313-264-0985

(For SGRX use only)

Date faxed: __/__/__

Date received: __/__/__

Date completed: __/__/__

Decision (all authorizations are pending valid eligibility)