PRIOR AUTHORIZATION GENERAL REQUEST FORM

Prescribing Physician	
Name (First, Last)	
Physician Specialty	
Phone #	Fax #

Name and title of person completing form (please print)

Patient	
Name (First, Last)	
ID #	Sex (at birth) ☐ M ☐ F
Phone #	Client
Birth Date	Age

1. Drug name:	2. Dose/Strength:	3. Frequency:	4. Duration:
5. Diagnosis:		6. ICD code:	

7. Has patient been on this drug?
☐ Yes ☐ No
If yes, for how long: ________________________________

8. Has the patient been seen by any other provider for this condition?
☐ Yes ☐ No
If yes, which specialty? ________________________________

9. 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

10. Please indicate pertinent laboratory tests or procedures for this diagnosis:

Drug name	Findings	Date

Physician's Name (print) ________________________________ **Title** ______________

Physician's Signature ________________________________ **Date** ______________

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

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