



REQUEST FOR PRIOR AUTHORIZATION

Prescribing Physician:		Patient:	
Name (First, Last)		Name (First, Last)	
Physician specialty		ID #	
Phone #	Fax #	Phone #	Client
Facility Name	Facility Phone #	Birth Date / /	Sex M <input type="checkbox"/> F <input type="checkbox"/>
Name and title of person completing form (please print)		Medication:	
Administration Type: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician office <input type="checkbox"/> Hospital <input type="checkbox"/> Home Health Care <input type="checkbox"/> Infusion Center		Drug name and strength:	
Fulfillment Type: <input type="checkbox"/> Buy and Bill <input type="checkbox"/> White Bag – medication received directly from a Specialty Pharmacy <input type="checkbox"/> Brown Bag – medication received from a patient		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? <input type="checkbox"/> Yes <input type="checkbox"/> 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** ___ / ___ / ___

(For SGRX use only)

Fax Request to: SGRX @ 313-264-0985

Date faxed: ___ / ___ / ___
Date received: ___ / ___ / ___
Date completed: ___ / ___ / ___

Decision (all authorizations are pending valid eligibility)
