



PRESCRIBER SERVICES
Prior Authorization Request

PRIOR AUTHORIZATION REQUEST FORM**

NOTE: This form must be completed by the prescribing physician. Because of the protected health information (PHI) contained, this form will be used only for purposes related to provision of treatment, payment and health care operations (TPO). This form and its contents are permissible under HIPAA. HIPAA does not restrict the communication of PHI to providers for TPO-related purposes.

Date of Request: _____

Case Number: _____

Plan Participant Name:	DOB:
Plan Participant ID Number:	TPC:
Physician Name:	DEA Number/Specialty:
Physician Phone Number:	Physician Fax Number:

Medication/Dose Requested: _____

To complete our review and to make an appropriate determination, the following information must be provided about your prior authorization request for the patient and medication listed above:

Diagnosis: _____ ICD-9 Code: _____

Previous drug treatment history: _____

Other relevant patient information: _____

Physician Signature*: _____ **Date:** _____

*The physician signature field must be completed. Requests will not be reviewed if this field is incomplete.

**Please call toll-free 1-800-952-9684 for assistance in filling out this form (physician offices only). While most requests are processed within one business day of receipt, some requests may require more time to review.

FAX COMPLETED FORM TO 1-800-230-0783.