

RX PRIOR AUTHORIZATION REQUEST FORM

Drug Name: _____

Patient Information

PATIENT NAME (LAST, FIRST, MI)			MEMBER ID
DOB	AGE	SEX	

Physician Information

PRESCRIBER'S NAME	CONTACT PERSON	NPI: TAX ID:
ADDRESS	PHONE	FAX

Medication Request

DIAGNOSIS / INDICATION - <i>For off-label indications, please supply authoritative medical literature to support this request</i>			ICD-10 CODE
DRUG NAME & STRENGTH REQUESTED	SIG	REFILLS	
ADMINISTRATION COST	MEDICATION COST		
DURATION OF THERAPY	NEW THERAPY <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF LAST EVALUATION (INCLUDE OFFICE NOTE)	NEXT APPOINTMENT-DATE

Place of Service

PLACE OF SERVICE NAME	NPI: TAX ID:
ADDRESS	PHONE FAX

Place of Service for Administration:

- Physician's Office
- Infusion Center
- Home Self-Injection
- Outpatient Facility
- Pharmacy
- Home Infusion
- Other

Information needed:

- Office Note
- Recent Imaging
- Current Symptoms
- Medications tried/failed
- Current labs

Notes: _____

Pharmacy UR Services - Phone: 740-455-5199 • Prior Authorization - Fax: 740-455-8817

This determination verifies participation in the review process and is based upon the medical information provided. This determination does not guarantee payment of benefits. Payment of benefits are determined by medical necessity, subsequent review of medical information or records, eligibility, contract limitations of the plan and provider network participation at the time the service is rendered.