



Prior Authorization Request Form

Please Fax to: (888) 465-9889

Date of Request: _____

Physician's Name: _____

Physician's DEA#: _____ Specialty: _____

Phone #: (____) _____ Fax #: (____) _____

Patients Name: _____ DOB: _____ Gender: _____

ID#: _____ Patient's Diagnosis: _____

Medication Needed: _____ Strength: _____

Quantity: _____ Directions: _____ Duration: _____

Has this patient tried other medications for this condition? (List drug, duration, results)

Clinical rationale for selected drug usage: _____

Is patient currently taking drug? _____ If so, how long? _____

***** All fields must be complete and legible for Prior Authorization Review*****

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