RX AMERICA
221 N Charles Lindbergh Drive
Salt Lake City, Utah 84116

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***