



REQUEST FOR MEDICATION AUTHORIZATION FORM

PLEASE FAX TO THE PRIOR AUTH DESK AT: (866)-855-2678 DATE OF REQUEST: \_\_\_\_\_

Name and Title of Person Completing This Form: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Extension: \_\_\_\_\_ Fax Number: \_\_\_\_\_

PRESCRIBING PHYSICIAN INFORMATION:

PATIENT / BENEFICIARY INFORMATION:

Name: \_\_\_\_\_
First Last

Name: \_\_\_\_\_
First Last

Direct Phone #: \_\_\_\_\_

Medicaid ID#: \_\_\_\_\_

Direct Fax #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Prescriber Specialty: \_\_\_\_\_

Patient's Gender: [ ] Female [ ] Male

Prescriber DEA#: \_\_\_\_\_

Table with 5 columns: Medication Name, Strength, Dose, Length of Therapy, Quantity

Diagnosis Related to this Medication: \_\_\_\_\_

Patient's Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Recent BP: \_\_\_\_\_ Date Taken: \_\_\_\_\_

1. Previous history of a medical condition, allergies or other pertinent information requiring the use of this medication: \_\_\_\_\_

2. Previous non-prior authorized and prior authorized medications tried and failed for this condition:

Table with 3 columns: Name of Medication, Reason for Failure, Date

3. Pertinent laboratory tests or procedures. (Please attach most recent info for best PA review results.)

Table with 3 columns: Test, Results, Date

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

RxAmerica Help Desk Number: 800-897-9469 \*Prior authorizations cannot be done over the phone.\*

Form with checkboxes for Approved, Denied, More Information Required, and fields for Date, Comments, and Reviewed By.

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