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:

Name: ____
First Last

Direct Phone #: ________________________________

Direct Fax #: __________________________________

Prescriber Specialty: ____________________________

Prescriber DEA#: ______________________________

PATIENT / BENEFICIARY INFORMATION:

Name: ____
First Last

Medicaid ID#: _______________________________________

Date of Birth: _______________________________________

Patient's Gender: ☐ Female ☐ Male

Medication Name	Strength	Dose	Length of Therapy	Quantity

Diagnosis Related to this Medication: ____

Patient's Height: _____________ Weight: _____________ BMI: __________ Date Calculated: ________________________

Recent Blood Pressure: ____________________________ Date Taken: ____________________

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

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

Name of Medication:	Reason for Failure:	Date:
____________________________	_______________________________	______/_______/___________
____________________________	_______________________________	______/_______/___________

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

Test:	Results:	Date:
____________________________	_______________________________	______/_______/___________
____________________________	_______________________________	______/_______/___________

*** All fields must be complete and legible for Prior Authorization Review***
CVS Caremark Help Desk Number: 800-897-9469 *Prior authorizations cannot be done over the phone.*

☐ Approved ☐ Denied ☐ More Information Required

Date: ___________________ Date: ___________________ Date: ____________________

Comments: ____

Reviewed By: ____

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