Send To: ❑ AcariaHealth
❑ Specialty Pharmacy Provider:_____

Prior Authorization Form
Specialty Drug

Phone: 1-800-218-7453 x22080
Fax: 1-866-683-5631

Date: _____ Date Medication Required:_____

Patient Name: _____
Address:_____
City:_____State:_____Zip:_____
Home Phone: (_____)_____- _____ Alt.
Phone: (_____)_____- _____
Cell Phone: (_____)_____ -_____
Patient Soc. Sec #: XXX-XX-_____
Date of Birth:___/___/___Sex: ❑ Male ❑Female Weight❑lbs ❑kg
Height:_____BSA:_____m²
County: _____

Physician Name: _____
StateLic#_____DEA # _____
NPI #_____UPIN# _____
Practice Name/Hospital: _____
Specialty: _____
Address: _____
City:_____State:_____Zip: _____
Physician's Phone: (_____)_____- _____
Physician's Fax: (_____)_____- _____
Nurse/Key Office Contact:_____Direct Ext: _____

INSURANCE INFORMATION (Please copy and attach the front and back of insurance and prescription drug card)

Prescription Card: Name of Insurer:_____ ID#:_____ BIN:_____PCN:_____ Group: _____
Primary Insurance: Subscriber:_____ ID#:_____ Name of Insurer:_____ Tel #: _____
Secondary Insurance: Subscriber:_____ ID#:_____ Name of Insurer:_____ Tel #:_____

DIAGNOSIS *(Required)*

What is the ICD-10 code? _____

PATIENT EVALUATION

1. Is the member currently treated with this medication?
   ❑ Yes; if yes please continue
   ❑ No; if no please continue to question #4

2. How long has the patient been on treated with this medication:_____❑ years ❑ months

3. Has the patient had a positive outcome? ❑ Yes ❑ No

4. Please indicate previous treatments and outcomes?

Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation
1.		
2.		
3.		
4.		

NOTE: confirmation of use will be made from member history on file; prior use of preferred drugs is part of the exception criteria

5. Please state Rationale for Request / Pertinent Clinical Information (Required for all prior authorizations)

NOTE: We can NOT make a decision without a copy of pertinent lab results and/or the current clinical progress notes - Thank You

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS

Physician's Signature: _____ Date____/_____/____