Part B Drug Prior Authorization Request Form

Certain requests for coverage require review with the prescribing physician.

Please complete this form and fax back to the number listed under the logo. Note any information left blank or illegible may delay the review process. Use one form per request.

Phone: 1-800-218-7508
Fax: 1-877-808-9368

I. MEMBER INFORMATION		II. PRESCRIBER INFORMATION	
Name:		Name:	
ID Number:		Specialty:	
Date of Birth:		NPI/DEA Number:	
Address:		Facility Name:	
City, State, Zip:		Address:	
Group Number:		City, State, Zip:	

III. MEDICATION REQUESTED	
Drug Name:	
Directions/SIG:	
Quantity:	
J-Code (if applicable):	

IV. ADDITIONAL CLINICAL INFORMATION	
ICD-9 Code:	
Diagnosis:	
Is the medication being requested for use in an ongoing investigational trial? ☐Yes ☐No	

V. MEDICATION HISTORY (for this diagnosis)

List therapeutic alternatives previously used with start/end dates and outcomes: Drug Name, Strength, and Dosage

	Drug Name, Strength, and Dosage	Dates of Therapy	Reason for Discontinuation
1			
2			
3			

VI. PERTINENT CLINICAL INFORMATION

NOTE: Please attach any pertinent medical history or information for this patient that may support approval.

EXPEDITED REVIEW: By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize the member's health, life or ability to regain maximum function.

Prescriber Signature:_____

Date:_____

STANDARD REVIEW

Prescriber Signature:_____

Date:_____