



Prior Authorization Request

Date of Request _____

Member Information

Name _____
 Enrollment / Cardholder ID _____
 Group / Plan _____
 Birth date _____
 Address: _____
 City State Zip _____

Relationship (Circle)

Subscriber Spouse Dependent

Gender (Circle)

Male Female
AGE: _____

Practitioner Information

Name _____
 Agent / Contact Name _____
 Specialty _____
 Office / Clinic Name _____
 Address _____
 City State Zip _____
 Phone () - _____
 Fax () - _____
 Email _____ @ _____

Requested Drug / Pharmaceutical

Strength / Dose

Duration of Therapy (Expected)

Condition / Diagnosis Related - Reason for Request

Type of Request (Circle)

One-Time On-Going

Clinical Drug / Lab History Pertinent to Request

Contact Pharmacy? Y N

Pharmacy Phone Number

Formulary Alternative(s) Attempted YES NO (Circle)

Practitioner Signature