FORM # RX006

Prior Authorization Request Form for Miscellaneous

Member Information

Patient Name _____

Cardholder ID _____

Date of Birth _____

Address _____

City, State Zip _____

Phone Number _____

Provider Information

Provider Name _____

DEA Number _____

Address _____

City, State and Zip _____

Phone Number _____

FAX Number _____

Pharmacy Information

Pharmacy Name_____Address_____Phone_____

Criteria for Approval

1. **Name and strength of drug requesting**:_____
2. Diagnosis that this is being used for:_____
   _____
3. Other medications previously tried and failed:_____
   _____
4. The patient is unable to take the drug preferred drug because:_____
   _____
5. Is this medication to be delivered through a nebulizer? Yes ☐ No ☐
6. Please submit additional documentation (labs, chart notes, etc.) supporting use.

Provider Signature _____ Date _____

Fax completed forms to (866) 284-4509.

For Office Use Only

Date/TimeReceived_____

ReferenceNumber_____

Approved / Denied (Circle One) by _____Date_____

Date/Time Returned to Provider_____

If you have any questions regarding this form, contact Prior Authorization Department Toll Free at (866) 284-4492 or FAX Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
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FOX Rx Care
We take your coverage personally.