

## 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/Time Received \_\_\_\_\_  
 Reference Number \_\_\_\_\_  
 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  
 3375-I Capital Circle NE  
 Tallahassee, FL 32308

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