Medication Prior Authorization Request Form

Patients Name: _____

Member #: _____

Phone #: (_____)_____

Date of Birth: _____

☐ **Male** ☐ **Female**

Physician Name: _____

Specialty: _____

Address: _____

_____

Phone #: (_____)_____

FAX #: (_____)_____

Requested Medication: _____ **Strength:** _____

Directions For Use: _____

DIAGNOSIS: _____

Date Patient Started this Medication: _____

NAME OF SPECIFIC DRUGS TRIED AND FAILED: _____

Reason For Non-Formulary Request. ***(Patient chart notes will be requested if further documentation is necessary)***

_____

_____

_____

Requesting Physician Signature: _____ **Date:** _____

Office Use Only

☐ **Approved**

Date Received : _____

Date Reviewed: _____

Approval Dates: _____ to _____

Signature: _____

Physician notified _____:_____ am/pm

☐ **Denied**

Date Received : _____

Date Reviewed: _____

Reason Denied: _____

_____

Signature: _____

1) **To Prescriber-** Complete ENTIRE form, SIGN and return to:

Prescription Solutions
3515 Harbor Blvd.
Costa Mesa, CA 92626
Phone # : 1-800-711-4555
Fax # : 1-800-527-0531
Mail Stop: LC07-286

2) Obtain Member's Pharmacy Name and Phone number.
3) Prescription Solutions will contact prescriber with decision or request for additional information.
4) Once approval is received, prescriber calls in prescription to member's pharmacy.
5) Authorization will be granted for length of therapy, unless otherwise noted.