Prior Authorization Request Form

Please fax the completed form to **703-991-4496**

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data) to support the prior authorization request**.**

☐ **Check if Urgent** **The prescriber attests that applying the standard turnaround time could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.*

Type of Request	
☐ New Therapy	☐ Renewal
☐ Pharmacy Billing	☐ Medical Billing

Patient Information					
First Name:	Last Name:	MI:	Phone Number:		
Address:	City:	State:	Zip Code:		
Date of Birth:	☐ Male ☐ Female	Circle Unit of Measure: Height: _____ (in/cm) Weight: _____ (lb/kg)	Allergies:		
Patient's Authorized Representative:	Authorized Representative Phone Number:				
Primary Insurance Name:	Primary Insurance ID Number:				
Secondary Insurance Name:	Secondary Insurance ID Number:				

Prescriber Information			
First Name:	Last Name:	Specialty:	
Fax Number:	Address:	City:	
State:	Zip Code:	Phone Number:	Email Address:
Requester (if different than prescriber):	Office Contact Person:		
NPI Number (individual):	DEA Number (if required):		

Medication/Medical Dispensing Information		
Medication Name:		
Dosage/Strength:	Frequency:	Length of Therapy:
# of Refills:	Quantity: (per 30 days)	JCODE:

Route of Administration:

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Inhalation ☐ Device ☐ Other _____

Administration Location:

☐ Patient's Home/Self- Administered ☐ Physician's Office ☐ Ambulatory Infusion Center ☐ Patient's Home/ Homecare-Administered ☐ Homecare Agency ☐ Outpatient Hospital Care ☐ Long Term Care ☐Other_____

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Patient Name	**Primary Insurance ID Number:**

New Therapy Clinical Information		
Previous Therapy: (Specify Drug Name and Dosage):	**Duration of Previous Therapy** (specify dates):	**Response/Reason for Failure/Allergy:**

List Diagnoses:	**ICD-10 Codes:**

Required Clinical Information- Please provide all relevant clinical information to support a prior authorization review.

Please provide symptoms, lab results with dates, and/or justification for initial or ongoing therapy or increased dose, and if the patient has any contraindications for the health plan/ insurer preferred drug. Laboratory results with dates are required if needed to establish diagnosis or evaluate response. Please provide any additional clinical information or comments pertinent to this requires for coverage (e.g., formulary tier exceptions.) ☐ Check if Attachments	**Current Medication List**

Complete for Renewal Therapy	
Date Therapy Initiated:	Response to Therapy:
Duration of Therapy (specific dates)	

Patient Pharmacy Information	
Pharmacy Name:	
Pharmacy Phone Number:	Pharmacy Fax Number:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or is designee may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____