

Prior Authorization Request Form for Prescription Drugs

Fax completed form to 678.236.0415.
This form is to be used by prescribers only.

Non-Urgent Request Urgent Circumstances (please include rationale in Section VI)

I. Prescriber Information (please print)			
Prescriber Name:		Office Contact:	
Prescriber NPI:		Specialty:	
Phone:		Fax:	
II. Member Information (please print)			
Member name:		Phone:	
Member ID #:		Date of Birth:	
Address:		City:	State: Zip:
Required to confirm address for any correspondence related to prior authorization(s)			
Medication allergies:			
III. Drug Information (one medication per request form)			
Drug name & strength:			
Directions:			
Diagnosis (ICD-10) relevant to this request:			
IV. Medication history for this diagnosis			
A. Is member currently treated with this medication? <input type="checkbox"/> Yes. For how long? _____ <input type="checkbox"/> No			
B. Expected Length of Therapy?			
V. Previous treatment and outcomes			
Note: Confirmation of use will be made from member claim history. Prior use of formulary drugs is part of the exception criteria. The PharmAvail formularies are located on the PharmAvail website at www.pharmavail.com .			
Drug name & strength	Dates of therapy	Reason for discontinuation	
VI. Clinical rationale for medication/urgent circumstances			
Prescriber/Agent Signature:			Date:

If marked as **urgent**, I attest this is an urgent case, meaning that an expedited (fast) determination is necessary to prevent serious threat to life, health, or the body's ability to regain maximum function; or is needed to manage severe pain.

Information on this form is Protected Health Information (PHI) and subject to all privacy and security under HIPAA.

Appropriate clinical information (including lab reports, when appropriate) to support the request on the basis of medical necessity must be submitted. PharmAvail is unable to evaluate any request without office notes.