Medication Prior Authorization Request Form

→ PLEASE BE SURE TO COMPLETE ENTIRE FORM ←

Your request cannot be processed without complete information

Patients Name: ____________________________

Member #: ________________________________

Phone #: (______)___________________________

Date of Birth: ______________________________

☐ **Male** ☐ **Female**

Physician: _______________________________

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)***

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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: __________________________________

To Prescriber- Complete ENTIRE form, SIGN, and send to:

PRESCRIPTION SOLUTIONS
3515 Harbor Blvd. Costa Mesa, CA 92626
Phone #: 1-800-711-4555
Fax #: 1-800-527-0531

*** PLS. NOTE: Prior Authorizations can now be requested via the Internet at www.RxSolutions.com ***

Go into the "Healthcare Professionals" section, under "Providers", select "Prior Auth. Request Form"