FUTURE SCRIPTS.

General Prior Authorization Form

ONLY COMPLETED REQUESTS WILL BE REVIEWED

☐ Gender Edit ☐ Quantity Edit ☐ Age Edit ☐ Prior Authorization

Drug Requested ______________________ Quantity ______________
(one drug per form only) (qty. edit only)

Date: ______________________ Patient ID#: ______________ DOB: __________

Patient Name: ______________________ Provider NPI: ______________________

Prescribing Physician: ______________________ Office Contact: ______________________

Office Fax #: ______________________ Office Phone: ______________________

ONLY COMPLETED REQUESTS WILL BE REVIEWED

******MEDICARE PART D ONLY: REQUESTS FOR OFF-LABEL USE REQUIRE SUPPORTING LITERATURE******

1. **PROVIDER SPECIALTY** (specify all) ______________________________

2. **DIAGNOSIS FOR DRUG REQUESTED** (specify all) ______________________________

3. **MEDICATION HISTORY** (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

Drug Name (dose and frequency)	**Duration of therapy (include dates)**	**Currently prescribed**
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

a. Is the patient currently not compliant on the regimen specific to the diagnosis? ☐ Yes ☐ No ☐ N/A

Please add any other supporting medical information that may be useful in the decision-making process:

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FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL