



**NON-FORMULARY MEDICATION/MEDICAL NECESSITY  
PRIOR AUTHORIZATION FORM**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Pharmacy Services. **FAX:** (888) 245-2049  
If needed, you may call to speak to a Pharmacy Services Representative.  
**PHONE:** (800) 392-1147 Monday through Friday 8:30am to 5:00pm

**PROVIDER INFORMATION**

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

**MEMBER INFORMATION**

Member Name:	DOB:	
Gateway ID:	Member weight:	Height:

**REQUESTED DRUG INFORMATION**

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Medication Initiated:

**Billing Information**

This medication will be billed: <input type="checkbox"/> at a pharmacy <b>OR</b> <input type="checkbox"/> medically, JCODE: _____
Place of Service: <input type="checkbox"/> Hospital <input type="checkbox"/> Provider's office <input type="checkbox"/> Member's home <input type="checkbox"/> Other

**Place of Service Information**

Name:	NPI:
Address:	Phone:

**MEDICAL HISTORY (Complete for ALL requests)**

Diagnosis:	ICD Code:
Is the member currently or recently hospitalized? <input type="checkbox"/> Yes, date of discharge: _____ <input type="checkbox"/> No	

*You must be able to document the therapeutic failure or contraindication to formulary products for a request to be approved.*

**CURRENT or PREVIOUS THERAPY**

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

**REAUTHORIZATION**

Has the member experienced a significant improvement with treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please describe:

**SUPPORTING INFORMATION or CLINICAL RATIONALE**


**Prescribing Provider Signature**

**Date**

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