



Prior Authorization Request Form

Please Fax to: (866) 930-0019

Date of Request: _____

Provider's Name: _____	
Provider's DEA/NPI: _____	Specialty: _____
Phone # _____	Fax # _____
Provider's Address: _____	

Member's Name: _____	DOB: _____
CSMG ID: _____	Gender: _____
Patient's Diagnosis: _____	

Medication Needed: _____	Strength: _____	Quantity: _____
Directions: _____	Duration: _____	
Refills _____	How many? _____	

Has this patient tried and failed other medications for this condition? (List drug, duration etc.)

Medication	Strength	Sig.	Duration

Clinical rationale for selected drug usage: _____

Is the patient currently taking this drug? _____

If so, how long? _____

What medications do you want to discontinue or stop? _____

Patient allergic to formulary alternative? _____

If yes, supply details: _____

***** All fields must be complete and legible for Prior Authorization Review *****

Confidentiality Notice: This Facsimile and any attached documents are confidential and are intended for the use of individual or entity to which it is addressed. If you have received this in error, please notify us by telephone immediately. For Ohio call 800-488-0134. For Michigan call 800-390-7102.