



## 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:

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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.