Pharmacy Prior Authorization Request Form

Pharmacy Fax Number: **1-866-930-0019** ☐ Standard ☐ Urgent

Note: Complete all sections – Incomplete or illegible forms will be returned and may delay processing.

MEMBER INFORMATION

Member First and Last Name	Date
Member ID	Date of Birth
Medication Allergies	Member Height (ft and in) and Weight (lbs)
Diagnosis Description	ICD-10 Code

PHARMACY INFORMATION

Pharmacy Name	Pharmacy Phone
NPI	

PRESCRIBER INFORMATION

Prescriber Name		Prescriber Specialty
NPI	Office Contact	Office Phone
Prescriber Address		Office Fax

MEDICATION REQUESTED

Drug Name and Strength	Quantity
Directions (Sig)	
Check if requesting brand: ☐	If brand, what is the medical reason why the brand is necessary? _____
Is the member currently treated on this medication? ☐ Yes; Date Started (mm/dd/yy): _____ ☐ No	

Member Name: _____
Member Date of Birth: _____

MEDICAL JUSTIFICATION

Please indicate previous treatments and outcomes below. COMPLETE ALL SECTIONS			
Previous Medication	**Strength**	**Dates of Use (mm/dd/yy to mm/dd/yy)**	**Reason(s) for Discontinuation**
1)			
2)			
3)			
4)			
5)			

Will the member be transitioning from another medication, titrating up/down and/or receive a loading dose as part of this request? If yes, please indicate the treatment plan.

☐ Yes; Treatment Plan: _____
_____

☐ No

Please list any other information you feel is important to this review. Examples include lab or test results, reason for a dosage form not preferred by the Plan, reason to quantity above what the Plan allows, etc. Attach relevant supporting documentation.

_____
_____
_____
_____

By signing this form, the provider attests above information is accurate and documented in the medical record.

Provider Signature	Date

NV-MED-P-4290506