

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

### PHARMACY INFORMATION

Pharmacy	Pharmacy Phone
Pharmacy National Provider Identification (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		

**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.

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

Provider Signature	Date
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The facsimile and any attached document 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 at 1-877-514-2442.