Prior Authorization Request Form

Phone: (800) 303-9626
Fax: (844) 807-8455

NOTE: Please ensure completion of this form in its entirety and attach required *documentation* for an accurate review.

PATIENT INFORMATION	PRESCRIBER INFORMATION
Full Name: _____	Full Name: _____ NPI #: _____
ID: _____	Specialty: _____
Date of Birth: _____	Office Contact Person: _____
Phone: _____	Office Phone: _____
Allergies: _____	Office Fax: _____
	Office Address: _____

PRODUCT INFORMATION

Request is for: **Medication Name: _____ Dose: _____ Frequency: _____**

☐ Initiation of therapy *If so,* Start date: _____

☐ Continuation of therapy *If so,* Start date: _____ End Date: _____ ***If YES, attach medical records***

DIAGNOSIS INFORMATION

☐ Diagnosis: _____

☐ ICD-10 Code: _____

CLINICAL INFORMATION

Has the patient tried and failure prior medications? ☐ Yes ☐ No *If yes,* How many? _____

1) Medication Name: _____ Dose: _____ Frequency: _____ Start date: _____ End Date: _____

2) Medication Name: _____ Dose: _____ Frequency: _____ Start date: _____ End Date: _____

3) Medication Name: _____ Dose: _____ Frequency: _____ Start date: _____ End Date: _____

Describe failure of therapy: ☐ No response ☐ Partial response ☐ Adverse effect

Please attach the most recent clinical notes or supporting documentation

I attest that this information is accurate and true, and that documentation supporting this information was attached and is available for review if requested by MetroPlus Health Plan or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy/)**

Please complete the following contact information in case additional information is needed.

Office Contact Person: _____ Contact Phone: _____ Ext #: _____

Date Form Completed and Faxed: _____

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