



**Medical Drug Authorization Request**  
**Drug Prior Authorization Requests Supplied by the Physician/Facility**

**Instructions:** To ensure our members receive quality care, appropriate claims payment, and notification of servicing providers, please complete this form in its entirety. **Fax completed form to <1-855-677-3913>.**

**By using this form, the physician (or prescriber) is asking for Medical drug coverage meeting one or both criteria:**

1. The drug is being supplied and administered in the physician's office. Provider will bill the health plan directly.
2. The drug is being supplied and administered at a facility or outpatient center. Facility/outpatient center will bill the health plan directly.

**Who is making this request?**  Provider  Member  Appointed Representative

*Appointed Representatives:* Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice.

**Please indicate:**

- Start of treatment: Start date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Continuation of therapy: Date of last treatment \_\_\_\_/\_\_\_\_/\_\_\_\_

**Priority Level**

- Expedited       Standard       Post-service

**Appointed Representative**

**Complete the following section ONLY if the person making this request is not the member or prescriber:**

Requestor's Name:	Requestor's Relationship to Member:
Address, City, State, ZIP:	
Requestor's Phone:	

**Member**

Member Name:	Member ID#:	
Member Address, City, State, ZIP:		
Phone:	DOB:	
Ht/Wt (lb/kg):	Allergies:	ICD-10:

**Requesting Provider**

Plan Provider ID Number:	NPI Number:	
Last Name:	First Name:	
Street Address:	City, State:	ZIP:
Phone Number	Fax Number:	
Provider Type/Specialty:	Name of Requestor:	

**Treating Provider/Vendor**

Out of Network    If Yes, Please Provide Reason:

Plan Provider ID Number:	NPI Number:	
Last Name:	First Name:	
Street Address:	City, State:	ZIP:
Phone Number	Fax Number:	
Provider Type/Specialty:	Name of Requestor:	

**Facility Information**

Type:  Office     OP Hospital     Home-Infusion/DME Provider    Tax ID:

Plan Provider ID Number:	NPI Number:	
Facility Name:	Phone Number:	Fax Number:
Street Address:	City, State:	ZIP:

**Medication/Service Requested**

Medication/HCPCS Code (s)	Dose	Visits/Frequency	Length of Treatment

*(Please use another form if more lines are needed.)*    **Physician Signature:**

Document clinical rationale for override/exception request. List names and doses of previous medication(s) tried and failed. Fax all supporting documentation.

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