

Pharmacy Services Prior Authorization Request Form

Please allow 24 to 48 hours after we receive all the information for a response.
For Medical Policy information please visit our website at: www.premera.com

Please fax this back to Pharmacy Services

Fax Number
1-888-260-9836

Phone Number
1-888-261-1756

Patient Name: _____	ID Number: _____		
Date of Birth: _____	ICD code: _____		
Prescriber's Name: _____	MD/DO/ARNP/PA-C (circle one)		
Fax Number: _____			
Prescriber's Address: _____			
Prescriber's Signature _____	Date _____	Phone Number _____	Ext. _____

Requested medication, CPT code, strength and dosing schedule

By checking this box you are certifying that a brand name contraceptive is medically necessary

Diagnosis related to use:

Medications Tried

	Medication name	Strength	Dosing schedule	Therapy duration	Dates tried	Reason therapy stopped
1						
2						
3						
4						
5						

Additional pertinent information

****Please submit this fax-back sheet along with relevant chart notes to Pharmacy Services****

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information

<i>Internal Use Only</i>	Approved Time Period: <input type="checkbox"/> _____ Months
<input type="checkbox"/> Approve/Fax	Start Date _____ End Date _____
<input type="checkbox"/> Deny	Date Approved _____ By _____

Unless specifically requested elsewhere in this document, please do **not** send a DNA or other genetic sample, or the results of any genetic typing, test or analysis, including DNA.

The information contained in this fax is confidential and intended only for the party named above. If you have received this communication in error, please immediately call us at the telephone number listed above.