CONTAINS CONFIDENTIAL PATIENT INFORMATION

Non-Preferred Medications Request
Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:

Prior Authorization of Benefits Center at (800) 601- 4829

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
_____	_____	_____	Specify: _____

7. DIAGNOSIS: _____

8 APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

☐ Yes ☐ No	Patient has previously tried and failed 2 (two) preferred products: One of which is in the same specific drug class; the other product has the same indication as the product requested **If yes**, please indicate trials below
☐ Yes ☐ No	For combination products: patient has tried 2 (two) preferred products: One of which is in the same specific class as at least one ingredient in the requested medication **If yes**, please indicate trials below
☐ Yes ☐ No	For non-preferred antibiotics/ anti-virals/ anti-fungals: patient has tried and failed on preferred antibiotic/ anti-viral/ anti-fungal product within the same route of administration **If yes,** please indicate trial below
☐ Yes ☐ No	Patient has previously taken the requested non-preferred product for 6 months **If yes,** please indicate trial below
☐ Yes ☐ No	Patient has a documented drug interaction
☐ Yes ☐ No	Patient has documented adverse drug experiences (side effects, adverse drug reaction)

Product 1: _____ Dates Tried: _____

Product 2: _____ Dates Tried: _____

9 PHYSICIAN SIGNATURE

_____ _____

Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.