Pharmacy Prior Authorization Request Form

Note: **To ensure that prior authorizations are reviewed promptly, submit request with current clinical notes and relevant lab work.**

Fax completed form to: (833) 951-1682

Date: ________________

Request Type: ❑ **Standard (72 hours)** ❑ **Expedited (24 hours)**

HEALTH PLAN

- ❑ **Banner Medicare Advantage DUAL (DSNP)**
- ❑ **Banner Medicare Advantage Prime (HMO)**
- ❑ **Banner Medicare Advantage Plus (PPO)**
- ❑ **Banner Medicare Simple Rx (PDP)**
- ❑ **Banner Medicare Classic Rx (PDP)**
- ❑ **Banner Medicare Premier Rx (PDP)**

MEMBER INFORMATION

Name: Last	First	MI

Date of Birth:	**Member ID#:**	**Phone:**

REQUESTING PROVIDER INFORMATION

First & Last Name:	**NPI:**

Phone:	**Fax:**

MEDICAL INFORMATION / MEDICATION REQUEST

Medication:	**Quantity:**	**Dosing Regimen:**	**Duration of Therapy:**

Relevant Diagnoses:

Reason for Exception:

Alternative Medication(s) Tried & Reason(s) for Failure:

For Office Use Only:

Fax completed form to: (833) 951-1682