



This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.

Additional forms available: [www.express-scripts.com/pa](http://www.express-scripts.com/pa)

Fax completed form to **1-877-251-5896**

If this is an **URGENT** request, please call 1-800-417-8164

**Patient Information**

Patient First Name: \_\_\_\_\_

Patient Last Name: \_\_\_\_\_

Patient ID#: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Patient Phone #: \_\_\_\_\_

**Prescriber Information**

Prescriber Name: \_\_\_\_\_

Prescriber DEA/NPI (**required**): \_\_\_\_\_

Prescriber Phone #: \_\_\_\_\_

Prescriber Fax #: \_\_\_\_\_

Prescriber Address: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **ICD Code:** \_\_\_\_\_

Please indicate which drug and strength is being requested: \_\_\_\_\_

Quantity Requested \_\_\_\_\_ for \_\_\_\_\_ days supply

Other Medications/Therapies tried and reason(s) for failure and/or any other information the physician feels is important to the review:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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