Independent Health

REQUEST FOR PHARMACY DRUG AUTHORIZATION

Member Name: DOB:

Member ID number: Date:

MD Name: MD NPI:

MD Fax Number: MD Phone Number:

Contact Person (if additional info is needed): Contact Person Phone Number:

Is this an appeal to a previously denied request *(please check one)***?** **YES** ☐ **NO** ☐

Drug Requested Name, Strength & Form:

Quantity Prescribed:

Expected Duration:

Directions for use:

Diagnosis:

Is this a renewal *(please check one)***?** **YES** ☐ **NO** ☐ **If YES, date drug was initiated**

Who will administer this medication *(please check one)***?** **MEMBER** ☐ **PROVIDER** ☐

Reason(s) Drug is Requested (please provide all relevant clinical information to support your request, you may attach additional documentation if needed):

Other Formulary Drugs tried:

Drug Name	Dates Tried	Reason for Failure

MD Signature: **Date**:

If you have any questions regarding this request, please contact the pharmacy department at (716) 631-2934 or (800) 247-1466 x5311 between the hours of 8:00 am and 6:00 pm Monday – Friday

Form may be mailed to:
Independent Health Association
Attn: Pharmacy Department
511 Farber Lakes Drive
Buffalo, NY 14221

or Faxed to:
(716) 631-9636, **OR** (716) 631-0149**,**
OR (800) 273-7397