



**Prescription Drug Authorization Request**  
**Fax Completed Form to (844) 357-2543**

Plan Option: PHP (HMO SNP)	
● Routine requests: processed within 72 hrs	
PHC-CA	
● All requests: processed within 1 business day	
PHC-FL	
● All requests: processed within 24 hours	
AHF	(Eligibility check)

- Please complete **all** sections legibly. Request will be processed within normal timeframes unless noted as an urgent request and the request meets urgent criteria.
- **Include all pertinent clinical documentation.** Failure to do so will result in a delay in processing.

**Member Information**

Member Name _____	Birth Date _____	Member ID Number _____
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**Drug Information**

Drug _____	Strength _____	<input type="checkbox"/> New <input type="checkbox"/> Refill Date drug Initiated: _____
Quantity _____	Directions for Use _____	
Diagnosis _____		
Duration of Therapy _____	Patient Allergies _____	

**Previous Therapies: Include Drug, Dose, and Duration**

\_\_\_\_\_

\_\_\_\_\_

**Rationale for Exception Request or Prior Authorization\***

- Contraindication(s) (list conditions): \_\_\_\_\_
  - Drug Interaction(s) (please specify): \_\_\_\_\_
  - Medical need for higher dosage: \_\_\_\_\_
  - All covered drug(s) on formulary contraindicated or previously tried, but with adverse outcome (toxicity, allergy, therapeutic failure): \_\_\_\_\_
- Explain medical rationale:  
 \_\_\_\_\_  
 \_\_\_\_\_

**\*Please provide lab data, discharge summaries, or progress notes as applicable**

**Prescriber Information**

Prescriber Name (Print) _____	Signature _____	Date _____
Prescriber Office Contact _____	Phone _____	Fax _____

**Pharmacy Information**

Pharmacy Name _____	Phone _____	Fax _____
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**For Health Plan Use Only**

Approved    Denied    Inquiry   Date of Action \_\_\_\_\_   Approved through \_\_\_\_\_

Completed By \_\_\_\_\_ Reviewed By \_\_\_\_\_

Comments: \_\_\_\_\_

<b>Reason for Auth Request</b>
<input type="checkbox"/> PA Required
<input type="checkbox"/> Non-Formulary
<input type="checkbox"/> Early Refill; Reason _____
<input type="checkbox"/> Quantity Limit
<input type="checkbox"/> Other _____

Positive Healthcare Pharmacy Services / Phone (888) 554-1334 / Fax (844) 357-2543

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