



Prescription Drug Authorization Request

Fax Completed Form to (844) 357-2543

- 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.

Plan Option:

- ☐ PHP (HMO SNP)
- Routine requests: processed within 72 hrs.
- ☐ AHF (Eligibility check)

Member Information

Member Name

Date of Birth

Member ID Number

Drug Information

Drug: _____ Strength: _____

Quantity: _____ Directions for Use: _____

Diagnosis: _____

Duration of Therapy: _____ Patient Allergies: _____

- ☐ New
- ☐ Refill
- Date drug Initiated: _____

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

For Health Plan Use Only

☐ Approved ☐ Denied ☐ Inquiry

Date of Action: _____ Approved Through: _____

Completed By: _____ Reviewed By: _____

Comments: _____

Reason for Auth Request

- ☐ PA Required
- ☐ Non-Formulary
- ☐ Early Refill; Reason _____
- ☐ Quantity Limit
- ☐ Other _____

PHP Pharmacy Services • Phone: (888) 554-1334 • Fax: (844) 357-2543

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