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