

# MEDICATION PRIOR AUTHORIZATION FORM

NOTE: Injectable prior authorization forms may be found at [www.passporthealthplan.com](http://www.passporthealthplan.com).

**Check one of the following:**

<input type="checkbox"/> <b>Standard Review</b> <b>FAX: (877) 693-8280</b> <b>[48 hours]</b>	<input type="checkbox"/> <b>Hospital Discharge FAX: (877) 693-8476</b> By checking this box and signing below, I certify this request is for a hospital discharge and have referred to the attached <i>Hospital Discharge Supplement</i> .	<input type="checkbox"/> <b>Urgent Review FAX: (877) 693-8476 [24 hours]</b> By checking this box and signing below, I certify that applying the 48 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.
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**Member Information**

<b>Member Name:</b>		<b>Date of Birth:</b>	
<b>Member ID Number:</b>		<b>Height/Weight:</b>	
<b>Drug Allergies:</b>			

**Fax Responses To:**

<b>Prescriber/Facility Fax Number</b>	<b>Pharmacy Fax Number</b>
_____	_____

**Provider Information**

Prescriber Information		Pharmacy or Hospital Information	
<b>Name/Specialty:</b>		<b>Name:</b>	
<b>Telephone Number:</b>		<b>Telephone Number:</b>	
<b>NPI Number:</b> <i>(Not DEA or Other Number)</i>		<b>NPI Number:</b> <i>(Not DEA or Other Number)</i>	
<b>Facility Name:</b> <i>(if related to a facility discharge)</i>		<b>Discharge Planner Name/Telephone:</b>	

**Diagnosis & Medical Information for Requested Medication**

<b>Diagnosis/ICD-9 Code:</b>	<b>Name of Drug:</b>	<b>Dosage Form:</b>	<b>Strength:</b>	<b>Quantity:</b>	<b>Duration of Therapy:</b>
_____	_____	_____	_____	_____	_____

**Directions for Use:** \_\_\_\_\_

Is the requested drug a previously prior authorized therapy?  YES  NO      If yes, is request a dose adjustment?  YES  NO

<b>Rationale for selecting requested medication:</b> <i>(Including drugs previously tried)</i>	<input type="checkbox"/> Lab/medical results are attached.				
	<b>Previous Therapy Drug Name:</b>	<b>Strength:</b>	<b>Directions for Use:</b>	<b>Outcomes/Effects:</b>	<b>Date Treatment Started:</b>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Prescriber Signature** \_\_\_\_\_