MEDICATION PRIOR AUTHORIZATION REQUEST FORM

Fax the completed form to **888.610.1180**

Electronic version available at **https://rxb.promptpa.com**

Incomplete form will delay the coverage determination. Please fill out all sections completely and legibly.

Request Date:	□ Request to expedite review

If the prescriber attests that applying the standard turnaround time could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or in the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request, please mark above the request to expedite this review process.

Patient Information

This section must be filled out completely to ensure HIPAA compliance

First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	□ Male □ Female	Height (in/cm): _____ Weight (lb/kg): _____ (Include If Applicable)	
Patient's Authorized Representative (if applicable):	Authorized Representative Phone Number:		

Prescriber Information

First Name:	Last Name:	Specialty:	
Address:	City:	State:	Zip Code:
NPI Number (individual):	Phone Number:		
Fax Number (in HIPAA compliant area):			

Dispensing Pharmacy Information

Pharmacy Name:	Pharmacy Location:
Pharmacy Phone Number:	Pharmacy Fax Number (in HIPAA compliant area):

Medication and Medical Information

Medication Name and Strength:	□ Dispense as written permitted* □ Generic substitution **default is generic substitution permitted*
Directions for Use:	Duration of Therapy:
□ New Therapy □ Continuation of Therapy - Start Date: _____	Please attach a copy of the prescription

If the patient has tried other medication(s) for this condition, please provide a list of previously tried and failed agents, including dates and reason(s) for failure

Reason for use of medication:	ICD 10 codes(s) and diagnosis:

Prescriber attests that the provided information is complete and accurate and understands that RxBenefits, Inc. reserves the right to perform an audit requesting the medical information necessary to verify accuracy at any time.

Prescriber Signature: _____ Date: _____