☐ **Urgent**	☐ **Non-Urgent**

Patient Information:	**Prescribing Provider Information:**
Patient Name:	Prescriber Name:
Member/Subscriber Number:	Prescriber Fax:
Policy/Group Number:	Prescriber Phone:
Patient Date of Birth (MM/DD/YYYY):	Prescriber Office Contact:
Patient Address:	Prescriber Address:
Patient Phone:	Prescriber NPI:
Patient Email Address:	Prescriber DEA:
	Prescriber Tax ID:
Prescription Date:	Specialty/Facility Name (If applicable):
	Prescriber Email Address:

Prior Authorization Request for Drug Benefit:	☐ New Request ☐ Reauthorization
Patient Diagnosis and ICD Diagnostic Code(s):	
Drug(s) Requested (with J-Code, if applicable):	
Strength/Route/Frequency:	
Unit/Volume of Named Drug(s):	
Start Date and Length of Therapy:	
Location of Treatment: (e.g. provider office, facility, home health, etc.) including name, Type 2 NPI (if applicable), address and tax ID:	
Clinical Criteria for Approval: [ADD ADDITIONAL LINES AS NEEDED SO AS TO CONTAIN ALL APPROVAL CRITERIA]	
For use in clinical trial? (If yes, provide trial name and registration number):	

Prescription:			
Drug Name (Brand Name and Scientific Name)/Strength:			
Dose:	Route:		Frequency:
Quantity:	Number of Refills:		
Deliver Product to:	☐ Patient's Home	☐ Physician Office	☐ Other:
Prescriber or Authorized Signature:			Date:
Dispensing Pharmacy Name and Phone Number:			

☐ **Approved**	☐ **Denied**
If Denied, Provide Reason for Denial:	