Print Form

PRESBYTERIAN

# Drug Prior Authorization Request Form

Fax: 1-800-724-6953
Fax: 1-505-923-5540

| (1)* Insurer: | (2)* Date: |
|---|---|

## Member Information

| (3) Group#: | (4) Member#: | (5) Name of Insured: |
|---|---|---|

| (6)* Patient Name, Last: | (7)* First: | (8) Initial: | (9)* DOB (mm/dd/yyyy): |
|---|---|---|---|

| (10)* Patient Address: | (11)* City: | (12)* State: | (13) Zip Code: | (14) E-mail: |
|---|---|---|---|---|

| (15) Primary Ph#: ( ) | Mobile #: ( ) | Work#: ( ) | (16) Height: | (17) Weight: | (18)* Gender M ☐ F ☐ |
|---|---|---|---|---|---|

| (19) BIN#: | (20) PCN#: | (21) Issuer#: | (22) Employer Name: |
|---|---|---|---|

## Prescriber Information

| (23) NPI#: | (24) DEA/XM#: | (25) * Specialty: | (26) Group practice or Organization: |
|---|---|---|---|

| (27) * Prescriber Name, First Last, and Title: | (28) Prescriber E-mail: | (29) Contact Name (Last, First): |
|---|---|---|

| (30) * Prescriber Address: | (31) * City: | (32) State: | (33) Zip Code: |
|---|---|---|---|

| (34) * Ph# & Ext.: ( ) | (35) Fax#: ( ) |
|---|---|

(36) * Prescriber Signature:

## Requested Medication

(37) * Diagnoses:

(38) Pending Discharge: Yes ☐ No ☐

| (39)* Drug or Item: | (40) J-Code: | (41)* Dosage: | (42) Frequency: | (43)* Qty.: | (44)* Days Supply: | (45)* Refills: |
|---|---|---|---|---|---|---|
| | | | | | | |

(46) * Reason for request/ Justification (e.g. other medications tried/ lab values. etc.):

Anticipated Duration of Treatment:

| (48) Start Date: | (49) End Date: |
|---|---|

## Pharmacy/ Facility Information

| (50) Pharmacy NPI#: | (51) * Pharmacy Address: |
|---|---|

| (52)* Pharmacy Name: | (53) * Fax#: ( ) | (54) * Phone# & ext.: ( ) |
|---|---|---|

* *Indicates information is required. Failure to provide sufficient information will result in a denial.*

The Drug Authorization Request Form may be downloaded from an insurer's website.

The request may originate from the prescriber or from the pharmacy. If originating at the pharmacy, the pharmacy must transmit the form to the prescriber for the justification, medical information, and the prescriber's or authorized representative's signature.

Blocks 1 and 2: **Insurer Information**

Provide the name of the insurer and the date of the request. Follow the instructions on the insurer's website for submission of the form for authorization. Note that the form may need to be submitted to a pharmacy benefits manager rather than directly to the insurer.

Blocks 3, 4, and 5: **Coverage Information**

Supply the information necessary to identify the insured member and the insured's policy following the instructions on the insurer's website.

Blocks 6 through 13, and 16 through 22: **Patient Information**

Provide the information as requested on the form. The blocks with an (*) are required.

19. BIN # - Bank Identification Number is a six digit number that tells the pharmacist which plan issuer or pharmacy benefits manager will reimburse them for the cost of the prescription and where to send the claim for reimbursement. (Term is misleading in that no bank is involved.)
20. PCN# - Processor Control Number is a secondary identifier that may be used in routing pharmacy transactions.
21. Issuer # - A 15 character identifier which signifies the plan issuer.

Blocks 14 and 15: **Patient Contact Information**

While not required, this information may help a pharmacy contact the patient (or the insured, parent, or guardian if a minor) regarding the status of the prescription.

Blocks 23 through 36: **Prescriber Information**

At a minimum, provide the information for the blocks that have an (*).

Block 26: Identify the group practice, clinic, or other entity with whom the prescriber is associated.

Block 29: Identify an individual within the office who may be efficiently contacted if there are questions regarding the request.

Block 36: The request must be signed by the prescribing practitioner or an authorized representative of the prescriber.

Blocks 37 through 49: **Requested Medication**

Provide sufficient information to identify the medication, the dosage and anticipated duration of treatment, etc.

Block 40: "J-codes" are primarily used by prescriber administered or prescriber dispensed drug items. The "J-codes" are found in the HCPC level II coding manuals, and often, but not always, begin with a "J". If not applicable, leave blank.

Block 46: Supply information that is reasonably necessary for approval of the drug or item. Insufficient information slows the process and requires additional contacts with the prescriber before the request can be approved.

Blocks 50 through 54: **Pharmacy or Other Dispensing Entity Information**

While not essential to complete this section, it is often efficient for the patient and all others to allow the insurer to work directly with the pharmacy or other facility to arrange for the dispensing. Sufficient information is necessary to assure the authorization is communicated to the correct dispensing pharmacy or other entity. Many pharmacies have the same name, so additional information is always required.