



Prior Authorization Request Form

THIS FORM IS TO BE USED BY PRESCRIBERS ONLY and REQUIRES PRESCRIBER SIGNATURE

Providers: Our electronic prior authorization (ePA) process is the preferred method for submitting pharmacy prior authorization requests. Creating an account is free, easy and helps patients get their medications sooner. You can complete the process through your current electronic health record/electronic medical record (EHR/EMR) system or by using one of these ePA sites:

CenterX (Epic: ePA workflow is automated during the order entry process)
CoverMyMeds (<https://www.covermymeds.com/main/prior-authorization-forms/>)
Surescripts (<http://providerportal.surescripts.net/providerportal>)

This form is being used for:

Check all that apply: ☐ Initial Request ☐ Continuation of Therapy/Renewal Request ☐ Request for Compound

☐ Other (please specify): _____

Patient Information:

Patient Name:	DOB:	Phone #:	
Address:	City:	State:	Zip:
Member ID#:	Plan Name:		
Requestor's Name & relationship to enrollee (if not patient or prescriber):			

Prescriber Information:

Prescribing Clinician:	Office Phone #:		
Specialty:	Office Secure Fax #:		
NPI #:	DEA:		
Address:	City:	State:	Zip:

Medication Information

Quantity Limit Requests

Requested Medication:	Please select all that apply:
Strength: Dosage Form:	☐ Request for titration (Provide titration schedule below)
Quantity: Day supply:	☐ Tried and failed plan's quantity limit (Provide rationale below)
Directions:	☐ Unable to dose consolidate (Provide rationale below)
Diagnosis(es) related to request:	☐ Requested strength/dose not commercially available
ICD-10 Code(s):	☐ Request is for insulin (Provide TOTAL daily units below)
	☐ Other (please specify):

Brand Request (DAW): ☐ Yes ☐ No

If Yes, has the patient had an allergic reaction (e.g., hives/urticaria, rash, anaphylaxis) to at least 1 generic manufacturer? ☐ Yes ☐ No

If Yes, has the patient had a non-allergic reaction, therapeutic failure, or side effect with at least 2 generic manufacturers (if available) of the requested drug? ☐ Yes ☐ No

If Yes, has a MedWatch form been submitted documenting the therapeutic failure or adverse outcome experienced? ☐ Yes ☐ No

Clinical Information and History

Drug Name	Strength	Dates of Use	Description of Adverse Reaction or Tried and Failed

This communication may contain information that is privileged, confidential, and exempt from disclosure under applicable law, including but not limited to, HIPAA. If you received this communication in error, you are hereby notified that any use or distribution of this communication is prohibited. Please immediately contact the original sender by calling the contact number noted, return all original documents, and destroy any copies.



Supporting information such as lab values, contraindications, allergies, or any other information relevant to this request.

Drug Allergies:

Height:

Weight:

Other:

☐ Urgent (Check the box if the request is URGENT)

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan, insurer, medical group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

PRESCRIBER SIGNATURE REQUIRED

Date:

Please contact MedImpact at 1-800-788-2949 should you have questions about this form or need assistance in filling it out.
Submit the completed form to MedImpact's PA Department fax number at (858) 790-7100