PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D vs B

Phone: 800-728-7947 Fax back to: 866-880-4532

Scott & White Prescription Services manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Specify drug requested.
Q2. Indicate directions for administration.
Q3. Indicate location of administration. ☐ Home ☐ Long Term Care (LTC) facility ☐ Physician office (drug from office stock) ☐ Physician office (drug from pharmacy with a prescription)
Q4. Provide diagnosis and ICD code.
Q5. Is the drug being used to prevent rejection of a transplanted organ? ☐ Yes ☐ No
Q6. If drug is being used to prevent rejection of a transplanted organ, was the transplant covered by Medicare?

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Patient Name:	**Prescriber Name:** **Supervising Physician:**

☐ Yes ☐ No
Q7. Indicate reason for request and attach supporting rationale to justify coverage of the drug.
Q8. Additional Comments:

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function