Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

Prescription Drug Prior Authorization Request Form

Please complete all fields in this form. Incomplete forms will delay processing time and drug therapy. If you have questions, please call 1-800-728-7947. **When complete, please fax this form to us at 1-866-880-4532.**

Date of Request _____

Member First Name _____

Member Last Name _____

Member Date of Birth _____

Member ID _____

Diagnosis and/or ICD Code _____

Drug Information

Name of Drug Request or Authorization _____

Drug Dose and Frequency _____

Duration of Treatment _____

Is this drug injectable? Yes or No _____

If injectable, indicate whether the drug will be obtained through the doctor's office or the pharmacy. _____

Indicate why formulary agent is not medically appropriate, methods tried, results and side effects. _____

Additional Comments _____

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Practitioner Information

Practitioner Name _____

Practitioner NPI _____

Supervising Physician Name (if applicable) _____

Supervising Physician NPI _____

Practitioner Phone Number _____

Clinic Name _____

Practitioner Secure Fax Number _____

Practitioner's Complete Mailing Address

Address _____

Mail Stop (if applicable) _____

City _____

State _____

ZIP Code _____

Please enter requestor's information below

Name of individual submitting request _____

Relationship to member _____

Requestor phone number _____