

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:
Member/Subscriber Number:	Supervising Physician:
Date of Birth:	Fax: Phone:
Group Number:	Office Contact:
Address:	NPI: State Lic ID:
City, State ZIP:	Address:
Primary Phone:	City, State ZIP:
	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. <input type="checkbox"/> Home <input type="checkbox"/> Long Term Care (LTC) facility <input type="checkbox"/> Physician office (drug from office stock) <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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:
<input type="checkbox"/> Yes	<input type="checkbox"/> 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

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