PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D vs B

Phone: 1-800-728-7947 Fax back to: 866-880-4532

SCOTT AND WHITE 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 Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State, Zip:	City, State, Zip:
Member Phone:	
Drug Name:	☐ Expedited/Urgent
Directions:	

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. Please indicate location of administration.

- ☐ Home
- ☐ Long Term Care (LTC) facility
- ☐ Physician office or clinic

Q4. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

- ☐ Pharmacy
- ☐ Individual prescriber
- ☐ Provider or specialty group
- ☐ Facility
- ☐ Other (please specify)

Q5. Provide name and NPI of the billing entity

Q6. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q7. Provide diagnosis and ICD code.

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Q8. Is the drug being used to prevent rejection of a transplanted organ?

☐ Yes ☐ No

Q9. If drug is being used to prevent rejection of a transplanted organ, was the transplant covered by Medicare?

☐ Yes ☐ No

Q10. Indicate reason for request and attach supporting rationale to justify coverage of the drug.

Q11. Additional Comments:

Physician Signature

Date