



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.



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.**

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

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document.