



PRIOR AUTHORIZATION REQUEST

Topical Quantity Limits

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number:	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength:	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Does the patient have a previously approved prior authorization (PA) for the requested medication in the last year on file with the current plan? [If no, skip to question 3.]	Yes	No
2	Is the request for continuation of therapy where the patient is stable and not experiencing any adverse effects? [No further questions.]	Yes	No
3	Is the requested medication being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? [If no, no further questions.]	Yes	No

**If you have any
questions, call:
1-888-258-8250**



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4	Is the requested medication being used in a footbath? [If yes, no further questions.]	Yes	No
5	Is the requested medication being used to treat an area that is greater than 10% of body surface area (BSA)? [If yes, no further questions.]	Yes	No
6	Is the maximum allowed quantity of the requested medication ineffective for the patient's treatment? [If no, no further questions.]	Yes	No
7	Can the prescribed dose be achieved with a lower quantity of a higher strength? [If yes, no further questions.]	Yes	No
8	Does the requested quantity, dose, and/or duration exceed the maximum FDA labeled dose for the requested indication?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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