FUTURE SCRIPTS Rx

Please complete ALL information below and fax your request to 1-888-671-5285

General Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required) | Provider Information (required)

Member Information	Provider Information	
Member Name:	Provider Name:	
Insurance ID#:	NPI#:	Specialty:
Date of Birth:	Office Phone:	
Street Address:	Office Fax:	
City: State: Zip:	Office Street Address:	
Phone:	City: State: Zip:	

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

What is the patient's diagnosis for the medication being requested (specify all)?

_____

ICD-10 Code(s): _____

Medication history (Please list any previous or current therapy related to the diagnosis, using drug names and dates):

Drug Name (dose & frequency)	Duration of therapy (include dates)	Currently prescribed
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No

Please add any other supporting medical information that may be useful in the decision-making process including contraindications to medications related to the diagnosis:

_____
_____

Quantity Limit Requests:

What is the quantity requested per MONTH? _____

Is there documentation of the inability to reach the requested dose with commercially available dosage forms? ❑ **Yes** ❑ **No**

Is there documentation the dose requested is medically necessary? ❑ **Yes** ❑ **No**

If YES, please specify: _____
_____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.