Medication Prior Authorization Form

MICHIGAN

Phone: 866-984-6462 Fax: 877-355-8070

Hospital Pending Discharge Fax: 313-465-1897

Instructions:

1. Only 1 medication per form
2. All fields must be completed and legible for review
3. Fax completed form to the appropriate number above, including all pertinent chart notes and lab values.

Prior Authorizations *cannot* be completed over the phone

To submit *electronically*, go to www.meridianrx.com and select "Submit Prior Authorization".

Date of Request:				
Is the patient hospitalized? ☐ **No** ☐ **Yes** **If Yes, please fax request to 313-465-1897.**				
Patient Information			**Prescriber Information**	
Patient Name:			Prescriber Name and Specialty:	
Member ID #:			NPI #:	
Sex: Male ☐ Female ☐			Office Phone:	
Date of Birth:			Office Fax:	
Patient Phone:			Contact Person:	
Service Type				
☐ Pharmacy/Retail			☐ Home Infusion/TPN/Enteral	
Diagnosis and Medical Information				
Medication:		Strength & Route of Administration:		Expected Length of Therapy:
Diagnosis Related to Medication Request:		Frequency:		Quantity:
BMI:	Date Calculated:	Blood Pressure:	Date Taken:	Height & Weight:
Drug Allergies:				

Rationale for Prior Authorization

History of a medical condition, allergies or other pertinent information requiring the use of this medication:

Previous use of non-authorized and prior authorized medications tried and failed for this condition:

Name of Medication	Reason for Failure	Date of Failure

You must include all necessary clinical documentation, office notes and all related laboratory results to ensure a complete PA review.

Prescriber's Signature:	Date: