



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	<u>If Yes, please fax request to 313-465-1897.</u>	
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:	

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