# Drug Request Form

The drug you are requesting requires prior authorization. Please complete this form, and fax the information to us. By filing out this form, it will provide us the information needed in order to expedite your request. ANY MISSING INFORMATION WILL ONLY DELAY THE PROCESSING OF YOUR REQUEST; you may fax them to the Medical Management Department at any time. Thanks in advance for your help. If you have any questions, please feel free to call customer service at **1-866-265-6578 Option 0**.

DATE OF REQUEST: _____

SENDER'S NAME: _____

REQUESTING PROVIDER NAME
(First & last name):_____

COMPLETE ADDRESS:
_____
_____

PROVIDER'S PHONE #: _____ FAX#:_____

PATIENT (first & last name):_____

INSURANCE ID#:_____ DOB:_____

---

DRUG NAME: _____STRENGTH: _____

DOSAGE/FREQUENCY: _____DURATION:_____

ICD-9CODE: _____ BEGIN DATE:_____

DX DESCRIPTION: _____

CLINICAL HISTORY (To support Dx)
_____
_____
_____
DRUG HISTORY: _____FAILED Tx_____
_____
_____
_____
LAB Hx: _____
(If applicable) HEP C GENOTYPE: _____

PLEASE FAX COMPLETED FORM TO 866-960-7716
ATTENTION: Stacy, Debbie & Cindy