

## Medication Prior Authorization Request Form

**Your request cannot be processed without complete information which includes provider specialty and address**

Member Name:	Provider Name:
Member ID:	Address:
Address:	
	Phone:
Phone:	Fax :
Date of Birth:	Specialty:

<b>Medication (drug &amp; strength):</b>	
<b>Directions for use:</b>	
<b>Diagnosis:</b>	
<b>Date patient started medication (if previously used):</b>	
<b>Name of specific medication(s) tried and failed:</b>	
<b>Reason for non-formulary request, and/or clinical justification for requested drug use:</b> <i>(Please include relevant lab values when appropriate. NOTE: Patient chart notes will be requested if further documentation is necessary.)</i>	
<b>Requesting Prescriber/Provider Signature:</b>	<b>Date:</b>
<b>Additional Notes:</b>	

**To Prescriber-** Complete ENTIRE form, SIGN and return to:

Prescription Solutions  
3515 Harbor Blvd.  
Costa Mesa, CA 92626  
Phone: 1-800-711-4555  
Fax: 1-800-527-0531

***Please call to expedite your request***