



☐ Urgent Review\*

☐ Standard Review

**\*Urgent Review criteria:** A request involving urgent care is one in which the time periods for making a non-urgent prescription medication determination could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or, in the opinion of the physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the prescription treatment that is the subject of this prior authorization.

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**PRESCRIPTION PRIOR AUTHORIZATION REQUEST FORM – PLEASE FAX FORM TO: 740-522-5002**

<b>MEMBER/PATIENT INFORMATION (REQUIRED)</b>					
Name:			SSN:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:			Date of Birth:		
City:	State:	Zip code:	Phone:		
Medication Allergies:		Pharmacy Name:		Pharmacy Phone:	
For Injectables Only Facility Name:			For Injectables Only Facility NPI#:		
<b>PROVIDER INFORMATION (REQUIRED)</b>					
Provider Name:		NPI#:	TIN#:	Specialty:	
Address:			Office contact name:		
City:	State:	Zip code:	Office Phone:		Office Fax:
<b>MEDICATION INFORMATION (REQUIRED)</b>					
Drug Name:		Strength:	Dose:	Directions (Sig):	
Duration Days:                      Months:		Quantity:	Refills:	Diagnosis:	
Is the Patient currently treated on this medication? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes", How long _____					
<b>CLINICAL INFORMATION (REQUIRED)</b>					
What medication(s) has the patient tried and failed?					
Are there any supporting labs or test results? <i>(Please specify)</i>					
Are there any other comments or information the physician feels is important to this review:					

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

By signature, the Prescriber (or agent of the prescriber) confirms that all information provided is accurate.

**\*\*\*In order for your request to be considered, all sections of this form must be completed. Please include all medical records. Most reviews will be concluded within 72 hours unless additional information is required or additional clinical review is needed. If we have further questions, office notes may be requested.\*\*\***