

Pharmacy Prior Authorization Form

Last Reviewed: Nov. 09

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Alprazolam ER

Urgent Non-urgent

| | |
|-------------------------------|-----------------|
| Member Name: | Member #: |
| DOB: | Gender: |
| Provider Name: | Provider Phone: |
| Provider Office Address: | |
| Provider Office Contact Name: | Provider Fax: |
| Provider Signature: | Provider NPI: |
| Date: | Member's PCP: |

Product:

- Alprazolam ER 0.5 mg
- Alprazolam ER 1 mg
- Alprazolam ER 2 mg
- Alprazolam ER 3 mg

Dose: _____ Start date: _____

Priority Health Precertification Requirements:

Authorization of alprazolam ER requires:

- Documented therapeutic trial of immediate release alprazolam

Patient has had a therapeutic trial of alprazolam immediate release:

- Yes - Dose: _____ Date: _____ Outcome: _____
- No – Rationale for use: _____

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX