

# Pharmacy Prior Authorization Form

Last Reviewed: Jan. 10

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

## Non-Covered Medication

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:

Medication Requested	Strength	Daily Dosage	Anticipated Length of Therapy
----------------------	----------	--------------	-------------------------------

### Priority Health precertification requirements:

All items must be completed:

1. Indication for requested medication:

\_\_\_\_\_

2. Justification for the use of requested product over Formulary medication:

\_\_\_\_\_

3. Similar medications used previously by patient:

Name	Date	Outcome
_____	_____	_____
_____	_____	_____

\*Please provide chart notes documenting medication trials if samples were given, or if the patient tried the medication when s/he was not a Priority Health member.

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

**Please fax this request to: (877)974-4411 toll free or (616)942-8206**  
**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**