Medicare Part D Request

Medication Prior Authorization Request Form

Patients Name: ______________________ **Physician Name:** ______________________

Specialty: ______________________

Member #: ______________________ **Address:** ______________________

Phone #: (____) ______________________ ______________________

Date of Birth: ______________________ **Phone #:** (______________________

☐ Male ☐ Female **FAX #:** (____) ______________________

Requested Medication: ______________________ **Strength:** ______________________

Directions For Use: ______________________

DIAGNOSIS: ______________________

Date Patient Started this Medication: ______________________

NAME OF SPECIFIC DRUGS TRIED AND FAILED: ______________________

Reason For Non-Formulary Request. ***(Patient chart notes will be requested if further documentation is necessary)***

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Requesting Physician Signature: ______________________ **Date:** ______________________

Office Use Only

☐ **Approved**	☐ **Denied**
Date Received : ____________	Date Received : ____________
Date Reviewed: ____________	Date Reviewed: ____________
Approval Dates: ________ to ________	Reason Denied: ____________
Signature: ____________	____________
	Signature: ____________

1) **To Prescriber-** Complete and return to: **Prescription Solutions**
3515 Harbor Blvd.
Costa Mesa, CA 92626
Phone # : 1-800-711-4555
Fax # : 1-800-527-0531

2) Obtain Member's Pharmacy Name and Phone number.
3) Instruct member to call prescriber in three (3) working days of request to check approval. If this request is for an acute medication, please call 1-800-711-4555.
4) Prescription Solutions will contact prescriber with decision or request for additional information.
5) Once approval is received, prescriber calls in prescription to member's pharmacy
6) Authorization will be granted for up to twelve (12) months unless otherwise noted.