Prescription Drug Prior Authorization Request

Prior Authorization is required for certain medications before your drug will be covered. Please consult the Prior Authorizations Medications List to determine if a prior authorization is required for a specific drug. If a prior authorization is required, your health care provider must submit the attached request form for approval.

INSTRUCTIONS: Use the attached form to initiate a prior authorization review.

1. Download this document, and fill out the form completely.
2. Attach any supporting documentation to the file.
3. Indicate whether this request is Urgent at the bottom of the form. "Urgent" is defined as when the member or their provider believes that waiting for a decision under the standard time frame could place the member's life, health or ability to regain maximum function in serious jeopardy.
4. Submit this request form and supporting documentation per details below.

PRIOR AUTHORIZATION SUBMISSION

Fax this completed form to our secure fax machine at: (855) 708-4808

or mail to:
Prescryptive Health
Pharmacy Prior Authorizations
PO Box 403
Redmond, WA 98073

For questions about this form or to inquire about a request under review, please call: **(206) 686-9016**

NOTIFICATIONS

Approvals and denials will be provided by mail to the address on the request or, if no address is included, the physical address we have on file. Letters are sent to both requesting provider and member.

NEW PRIOR AUTHORIZATION FORMS

This form can be found at: www.prescryptive.com/prescriber

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REWRITING THE SCRIPT

Prior Authorization Request Form

Fax this completed form with relevant chart notes to (855) 708-4808

or mail to:

Prescryptive Health
Pharmacy Prior Authorizations
PO Box 403
Redmond, WA 98073

Please allow 24-48 hours for a response once all relevant information has been supplied.
For a complete list of medication policies, please visit **prescryptive.com**. Call **(206) 686-9016** for assistance.

Patient Name:			Date of Birth:
ID Number:	Phone Number:		Today's Date:
Prescriber Name:		Specialty:	Prescriber Degree: (check one) ☐ MD ☐ DO ☐ ARNP ☐ PA-C
Prescriber Address:			NPI/ID #:
Phone Number:	Fax Number:		Contact Name:
Prescriber Signature:			Date:

Requested Medication:		Diagnosis:	
Dose:	Frequency:	Quantity:	ICD 10:
Directions:		Anticipated Duration:	

All Medications previously tried for this diagnosis:

Medication /Dosage	Date(s) of Treatment	Outcome	Reason for stopping

Medical Rationale:

Is this request Urgent? ☐ **Yes** ☐ **No**

***Urgent is defined as when the member or their provider believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.**

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