coordinated care

Phone: (855) 304-5580 Fax: (855) 815-9894

General Specialty Medication PA Form

Prior Authorization Form/ Prescription

Date: _____ Date Medication Required:_____
Ship to: ❍ Physician ❍ Patient's Home ❍ Other _____

Patient Information

Last Name:	First Name:	Middle:	DOB: ____/____/_____
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	Sex: ☐ Male ☐ Female	

Insurance Information (Attach Copies of cards)

Primary Insurance:		Secondary Insurance:	
ID #	Group #	ID #	Group #
City:	State:	City:	State:

Physician Information

Name:	Specialty:	NPI:	
Address:	City:	State:	Zip:
Phone # ( )	Secure Fax #: ( )	Office contact:	

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS

Primary Diagnosis

Primary ICD-9/ICD-10 Code: _____

Description in words: _____

Clinical Information ***** Please submit supporting clinical documentation*****

☐ **INITIAL THERAPY** ☐ **CONTINUATION OF THERAPY;** Therapy start date: _____

Patient's weight _____ kg Patient's height _____ inches

1. Is the member currently treated with this medication? ☐ Yes ☐ No
2. If continuation of therapy, how long has the patient been on treatment? _____ ☐ years ☐ months
3. Has the patient had a positive outcome? ☐ Yes ☐ No
4. Please indicate previous treatment and outcomes?

Note: This form is to be used to request review for Specialty Medication where there is no drug specific form. For non-specialty medication, please use US Script Prior Authorization form.

Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation
1.		
2.		
3.		
4.		

NOTE: confirmation of use will be made from member history on file; prior use of preferred drugs is part of the exception criteria

5. Please state Rationale for Request / Pertinent Clinical Information (**Required for all prior authorizations**)

Physician's Signature _____ **Date:** _____ ☐ DAW