PRIOR AUTHORIZATION REQUEST
FOR DRUGS COVERED UNDER THE MEDICAL BENEFIT

(I.E. DRUGS GIVEN VIA IM OR IV ADMINISTERED IN AN OFFICE, HOME, OR OUTPATIENT SETTING)
PLEASE FAX TO 234-231-7082 *FOR URGENT REQUESTS ONLY, PLEASE CALL 330-996-8710

DATE: ________________ **MEMBER'S PHONE#** ______________________________

MEMBER NAME____
LAST FIRST MI

MEMBER ID# _____________________________ **MEMBER DOB**________________

ORDERING PHYSICIAN'S NAME____
LAST FIRST

NPI#______________________________ **TAX ID#**____________________________

ADDRESS____

PHONE# __________________________________ **PHONE# OPTION/EXT**_________

OTHER CONTACT NAME____________________ **FAX#**________________________

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PROCEDURE ORDER

***HAS THE SERVICE BEING REQUESTED ALREADY BEEN PERFORMED?** **YES** ☐ **NO** ☐

*** IS THE PROVIDER BUYING AND BILLING FOR THE MEDICATION?** **YES** ☐ **NO** ☐

☐ NEW REQUEST ☐ REAUTHORIZATION REQUEST

DATE OF SERVICE_________________________ **DIAGNOSIS**___________________
HCPCS (J-CODE) __________________________ **ICD-10 DX CODE**_______________
NAME OF DRUG ___________________________________
SERVICE REQUESTED/ADDITIONAL NOTES _________________________________

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CLINICAL INFORMATION – PERTINENT TO DRUG BEING REQUESTED (ATTACH COPIES OF PERTINENT CLINICALS)

PLACE OF SERVICE - FACILITY/PROVIDER (DOCTOR'S FULL NAME)

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NPI#______________________________ **TAX ID#**____________________________
ADDRESS____
PHONE# __________________________________ **FAX#**________________________

***CLINICAL INFORMATION* – PERTINENT TO PROVIDER SERVICE (ATTACH COPIES OF PERTINENT CLINICALS)**
Include symptoms/findings, medications, labs, tests, imaging & conservative treatment (if any)

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