

Prior Authorization Request Form: Medications Please type or print neatly. Incomplete and illegible forms will delay processing.

I. Provider Information			II. Member Information		
Prescriber name	NPI#		Member name		Today's date
Prescriber specialty	Phone		Member plan ID #		Date of birth
,					
Prescriber address			Orug allergies		
Office contact name	Fax		Plan name and fax for form submission		
Pharmacy name	Pharmacy phone				
Filamacyname					
III. Drug Information (one o	drug per request	form)			
Drug name Dr	rug strength	Dosage form	Dosage interval	Qua	ntity per day
Diagnosis relayant to this request				ICD	9 code
Diagnosis relevant to this request				ICD-	9 code
Expected length of therapy					nber of refills
IV. Drug History for this Dia	agnosis				
A. Is the prescription for a drug t	o be administered in	n the office or for the memb	er to take at home?	office home	
B. Is the member currently treat	ed on this drug?	Yes: how long?	[go to item C]	No [skip items C and	d D; go to item E]
C. Is this request for continuation	n of a previous appr	oval? Yes [go to item D]	No [skip item D; go to ite	m E]	
D. Has strength, dosage or quant	tity required per day	increased or decreased?			
Yes [go to item E] No [s	skip item E; indicate	rationale in Section V and su	ubmit form]		
E. Please indicate previous treat	ments and outcome	s with other medications be	low.		
Drug name	Drug name Strength Directions Dates		Dates of therapy	of therapy Reason for failure or discontinuation	
V. Rationale for Request and	d Pertinent Clini	cal Information (attach	additional sheets if m	ore space is neede	d)
Appropriate clinical information to support the rec	quest on the basis of medical r	necessity must be submitted.			
Prescriber/Authorized Representative signature				Date	

Plan Fax Numbers Absolute Total Care 1.866.399.0929

First Choice by Select Health. . . . 1.866.610.2775

Healthy Blue by BlueChoice of SC. 1.866.807.6241 Molina Healthcare of SC. 1.855.571.3011 Wellness of SC. 1.866.354.8709