



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 330.996.8992 *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#** _____

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 _____

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

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

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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