

PRIOR-AUTHORIZATION FORM- GENERAL

Patient Information	
Member's name	
Member's ID number	
Member's telephone number	
Prescriber Information	
Physician's name	
Physician's medical specialty	
Physician's telephone number	
Pharmacy Information	
Pharmacy's name	
NPI number	
Pharmacy's telephone number	

Please provide all requested information. Incomplete forms will be returned. Prescription copy is required for evaluation.

MEDICATION REQUESTED: _____

DURATION OF TREATMENT: _____

DIADNOSIS: _____

REASON FOR REQUEST: _____

PREVIOUSLY USED MEDICATIONS FOR CONDITION: _____

Printed Name: _____ Signature: _____

Please specify contact's person name (if different from above): _____

For PharmPix use:

Date received _____ Date reviewed _____ By (initials) _____

Approved/Denied _____ Notification Date _____ By (initials) _____

The information transmitted is intended only for the person or entity to which it is addressed and may contain lawyer/client and/or corporate, privileged confidential material. Any review, retransmission, dissemination, printing or other use of, or taking of any action in reliance upon, this information by persons or entities other than the intended recipient is strictly prohibited. Anyone who voluntarily and/or willingly alter, manipulates, use and/or make public these contents and/or attachments could face criminal charges and will be liable for civil damages. If you receive this in error, please immediately contact (reply) the sender by e-mail or by telephone at 787-522-5252, Then delete and destroy all copies, printed or e-mailed, of this communication and its attachments thereof on hand and from your system.

CHANGING THE WAY PBMs WORK, NOW AND FOR EVER

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