



Phone: 866-329-4701
 Fax: 855-217-0926

Send To: AcariaHealth
 Specialty Pharmacy Provider: _____
 Date: _____ Date Medication Required: _____
 Ship to: Physician Patient's Home Other _____

Prior Authorization Form General

Patient Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Patient Soc. Sec #: _____ Allergies: _____ Date of Birth: ___/___/___ Sex: <input type="radio"/> Male <input type="radio"/> Female Weight ___ lbs <input type="radio"/> kg Height: _____ BSA: _____ m ² <input type="radio"/> See attached demographic sheet	Physician Name: _____ State Lic # _____ DEA # _____ NPI # _____ Specialty: _____ Practice Name/Hospital: _____ Address: _____ City: _____ State: _____ Zip: _____ Physician's Ph: (____) _____ - _____ Physician's Fax: (____) _____ - _____ Nurse/Key Office Contact: _____
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INSURANCE INFORMATION (Complete or Attach Copies of cards)			
Primary Insurance: _____ City: _____ State: _____ Plan #: _____ Group #: _____ Phone: (____) _____ - _____	Secondary Insurance: _____ City: _____ State: _____ Plan #: _____ Group #: _____ Phone: (____) _____ - _____	Rx Card (PBM): _____ PBM BIN: _____ City: _____ State: _____ Group #: _____ Phone: (____) _____ - _____	Cardholder First Name: _____ Last Name: _____ Employer: _____ ID #: _____ Group #: _____

DIAGNOSIS (Required)
What is the ICD 9 / ICD 10 code? _____

PATIENT EVALUATION															
<ol style="list-style-type: none"> 1. Is the member currently treated with this medication? <input type="checkbox"/> Yes; if yes, please continue <input type="checkbox"/> No; if no, please continue to question #4 2. How long has the patient been on treated with this medication: _____ <input type="checkbox"/> years <input type="checkbox"/> months 3. Has the patient had a positive outcome? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Please indicate previous treatments and outcomes? <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width:35%;">Drug Name (include strength and dosage)</th> <th style="width:30%;">Dates of Therapy</th> <th style="width:35%;">Reason for Discontinuation</th> </tr> </thead> <tbody> <tr><td style="text-align: center;">1.</td><td> </td><td> </td></tr> <tr><td style="text-align: center;">2.</td><td> </td><td> </td></tr> <tr><td style="text-align: center;">3.</td><td> </td><td> </td></tr> <tr><td style="text-align: center;">4.</td><td> </td><td> </td></tr> </tbody> </table> <p style="font-size: small; margin-top: 5px;">NOTE: confirmation of use will be made from member history on file; prior use of preferred drugs is part of the exception criteria</p>	Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation	1.			2.			3.			4.		
Drug Name (include strength and dosage)	Dates of Therapy	Reason for Discontinuation													
1.															
2.															
3.															
4.															
5. Please state Rationale for Request / Pertinent Clinical Information (Required for all prior authorizations) <p style="text-align: center; font-weight: bold; font-size: small;">**NOTE: We can NOT make a decision without a copy of pertinent lab results and/or the current clinical progress notes - Thank You**</p>															

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS

Physician's Signature: _____ DAW (Dispense as Written) Date ___/___/___

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