



## Medication Prior Authorization Request Form

**\*Your request cannot be processed without complete information this includes provider specialty and address\***

Member Name:	Provider name:
Member ID:	Address:
Address:	Phone:
Phone:	Fax :
Date of Birth:	Specialty:

**Medication:** \_\_\_\_\_ **Strength:** \_\_\_\_\_

**Directions for use:** \_\_\_\_\_

**Diagnosis\*:** \_\_\_\_\_

**Date patient started medication:** \_\_\_\_\_

**Name of specific meds. tried and failed:** \_\_\_\_\_

**Reason For Non-Formulary Request. (Patient chart notes will be requested if further documentation is necessary)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Requesting Physician's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Additional notes:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**To Prescriber-** Complete ENTIRE form, SIGN and return to:

**Prescription Solutions  
3515 Harbor Blvd.  
Costa Mesa, CA 92626  
Phone: 1-800-711-4555  
Fax: 1-800-527-0531**

**\*\*\*Please call to expedite your request\*\*\***