ProCare

REQUEST FOR PRIOR AUTHORIZATION

☐ Adult Benefit Waiver (ABW) ☐ HealthChoice ☐ Medicaid

Prescribing Physician:

Name:_____ ____
First **Last**
Direct Phone #: (_ _ _) _____

Fax #: (_ _ _) _____ ____

Physician specialty: _____

Patient:

Name:_____
First **Last**
ID#: _____

Phone #: _____

Birth Date: _ _ - _ _ - _ _ _ _ **Sex:** ☐ **Female** ☐ **Male**

Name and title of person completing form (please print): _____

Drug name:	**Strength:**	**Administration Schedule:**	**Length of Therapy:**	**Quantity Requested:**
a)				
b)				
c)				

Has patient been on this drug and, if yes, for how long at this dosage? _____

Patient's diagnosis requiring the use of this medication: _____

1. Previous history of a medical condition, allergies or other pertinent medical information that necessitates the use of this medication: _____

2. Has the patient been seen by any other provider for this condition? ☐ **Yes** ☐ **No**
If so, what was the prescriber's specialty? _____

3. Previous non-prior authorized and prior authorized medications tried and failed for this condition:

Name of medication	**Reason for failure**	**Date:**
_____	_____	_ _ / _ _ / _ _ _ _
_____	_____	_ _ / _ _ / _ _ _ _
_____	_____	_ _ / _ _ / _ _ _ _

4. Pertinent laboratory test or procedure: (if applicable)

Procedure:	**Findings:**	**Date:**
_____	_____	_ _ / _ _ / _ _ _ _
_____	_____	_ _ / _ _ / _ _ _ _
_____	_____	_ _ / _ _ / _ _ _ _

5. Other Information: _____

Fax Request to: ScriptGuideRX @ 313-499-3201

For ScriptGuideRX use only

Date faxed:

Date received:

Date completed:

Decision (all authorizations are pending valid eligibility):

15400 E. Jefferson Avenue ♦ Grosse Pointe Park ♦ MI ♦ 48214 ♦ 855-855-SGRX, ext 207
www.scriptguiderx.com