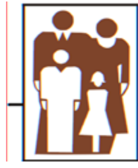

ProCare Health Plan

Request for Pharmacy Prior Authorization

(ALL FIELDS MUST BE COMPLETE AND LEGIBLE FOR REVIEW)

ABW **MEDICAID** **HEALTHCHOICE** **BASIC CARE**

Fax to: Prior Authorization: 1-866-250-5178 Date of Request: __________________

(Please Note: Routine Requests may take up to 72 Hours or Next Business Day)

Patient's Name:______________________________ _DOB:________________ Gender: ________

ID#: ____________________________________ Dx: ______________________________________

Prescribing Physician Name: ____________________________ Specialty ______________________

Physician's Phone #: __________________________________ Fax: __________________________

Physician DEA#: ____________________________NPI#:___________________________________

Medication Needed:__________________________________ **Strength:**________________________

Quantity:____________ **Directions:** ____________________________**Duration:**__________________

Has this patient tried other medications for this condition? (List drug and duration)

____

____

Clinical rationale for requested drug:____

____

Provide clinical documentation including information regarding trial and failure of formulary agents to support your prior authorization request.

Pertinent laboratory tests or procedures and results:____
____
____

Is patient currently taking drug?____________ If so, how long?_________________________________

*****All fields must be complete and legible for Prior Authorization Review*****

****Please note that prior authorizations will not be done over the phone****

The documents accompanying this transmission contain confidential health information. If you are not the intended recipient and have received this information in error, please notify the sender (by return fax) immediately and arrange for the return or destruction of these documents.