REALRx

PRIOR AUTHORIZATION REQUEST FORM

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Member Information	Prescriber Information
Member Name:	Prescriber Name and Specialty:
Member ID#:	Prescriber NPI#:
Member Date of Birth:	Prescriber Office Phone:
Member Phone:	Prescriber Secure Fax:
Member Drug Allergies:	Prescriber Office Contact:

Diagnosis and Medical Information

Drug Name and Strength Requested:	Diagnosis & ICD Code:
Dosing Instructions:	Quantity per 30 Days:

Questions	Yes	No
1. Is the requested medication being purchased by the provider's office and to be billed under the medical benefit ('buy-and-bill')?	☐	☐
2. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐

Previous Formulary Trial(s)

Drug Name/Strength Dosage	Date(s) and Duration of Trial	Treatment Outcome

Request Rationale

History of a medical condition, allergies or other pertinent information requiring the use of this medication:

_____

_____

_____

Prescriber Signature:	Date:

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