

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**  
**Non-Preferred Medication Request**

**Prior Authorization of Benefits (PAB) Form Complete form in its entirety and fax to:  
 Prior Authorization of Benefits Center at 844-474-3341**

**1. PATIENT INFORMATION**

Patient Name: \_\_\_\_\_  
 Patient ID #: \_\_\_\_\_  
 Patient DOB: \_\_\_\_\_  
 Date of Rx: \_\_\_\_\_  
 Patient Phone #: \_\_\_\_\_  
 Patient Email Address: \_\_\_\_\_

**2. PHYSICIAN INFORMATION**

Prescribing Physician: \_\_\_\_\_  
 Physician Address: \_\_\_\_\_  
 Physician Phone #: \_\_\_\_\_  
 Physician Fax #: \_\_\_\_\_  
 Physician Specialty: \_\_\_\_\_  
 Physician DEA: \_\_\_\_\_  
 Physician NPI #: \_\_\_\_\_  
 Physician Email Address: \_\_\_\_\_

**3. MEDICATION****4. STRENGTH****5. DIRECTIONS****6. QUANTITY PER 30 DAYS**

_____	_____	_____	Specify: _____
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**7. DIAGNOSIS:**

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**8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**

**NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.**

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Has the patient has had treatment failure with one preferred product? <b>If yes</b> , please indicate which product: _____
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Does the patient have a contraindication to one preferred product? <b>If yes</b> , please indicate which product: _____
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Has the patient had an allergic reaction to one preferred product? <b>If yes</b> , please which product: _____
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

**9. PHYSICIAN SIGNATURE**

_____ Prescriber or Authorized Signature	_____ Date
<i>Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.</i>	
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.	
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