REQUEST FOR PRIOR AUTHORIZATION

Prescribing Physician:	
Name (First, Last)	
Direct Phone #	
Fax #	
Physician specialty	

Patient:	
Name (First, Last)	
ID #	
Phone #	Client
Birth Date ___/___/_____	Sex ☐M ☐F

Name and title of person completing form (please print)			
Drug name:	Strength:	Length of Therapy:	Quantity Requested:
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? If so, what was the prescriber's specialty?		☐Yes ☐No	
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:			

Physician's Signature _____ **Date** ___/___/_____

Fax Request to: SGRX @ 313-264-0985

For ScriptGuideRX use only)

Date faxed: ___/___/_____ Date received: ___/___/_____ Date completed: ___/___/_____	Decision (all authorizations are pending valid eligibility)