Prior Authorization Form

This form must be completed by the prescriber or authorized personnel. INCOMPLETE FORMS WILL BE RETURNED

Member Information

LAST NAME: | **FIRST NAME:**

ID NUMBER: | **DATE OF BIRTH:** ___ – ___ – ____

Prescriber Information

LAST NAME: | **FIRST NAME:**

NPI NUMBER: | **DEA NUMBER:**

PHONE NUMBER: ___ – ___ – ____ | **FAX NUMBER:** ___ – ___ – ____

Requested Medication

Medication: _____

Strength: _____ Directions: _____

Quantity: _____ Duration of Therapy: _____

Clinical Criteria Documentation

GlobalHealth benefits require covered medications to be prescribed in adherence to FDA-approved and manufacturer-recommended indications, strength, dosage, treatment duration, etc. Please refer to the requested product's Prescribing Information, generally available on the manufacturer's website, for detailed product information.

1. **What is the primary diagnosis?** _____ **ICD Code:** _____
2. **Indicate the request type** ☐ New Start ☐ Renewal. **Date therapy was started**: _____
3. **Please list ALL medications, both OTC and prescription, the patient has tried specific to the diagnosis**.

Drug Name	Strength	Dosing Schedule	Duration of therapy	Reason of Failure
a.				
b.				
c.				
d.				

4. **Reason for non-formulary request, and/or clinical justification for requested drug use.** *(Please include relevant lab values and chart notes)* _____
   _____
   _____
5. **May the patient use generic equivalent if available**? ☐ Yes ☐ No
   If **NO**, please explain: _____
6. **Does the patient have any known contraindications to the requested product**? ☐ Yes ☐ No
   If **YES**, please explain: _____

_____ _____

Prescriber Signature (Required) ***Date***

(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)

Fax this form to: 1-800-424-7573

Phone 1-800-424-1789

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