



MEDICARE PART D PRESCRIPTION DRUG AUTHORIZATION REQUEST FORM

This form is for authorization of prescription drug benefits only and must be COMPLETELY filled out.

STANDARD REQUEST EXPEDITED REQUEST

GENERAL INFORMATION *Request Type (please check one)*

Prior Authorization
 Step Therapy Exception
 Request Non-formulary Drug
 Request for Tiering Exception
 Request for Quantity Limit Exception
 Appeal

Patient Name			Date of Birth (mm/dd/yyyy)							
			M	M	D	D	Y	Y	Y	Y
Patient's Home Address			Contract Number (include prefix)							
City	State	Zip								

PHYSICIAN INFORMATION

Physician Name			Practice Type					
			<input type="checkbox"/> PCP <input type="checkbox"/> Specialist					
Practice Address			Physician UPIN					
City	State	Zip	Provider Number					
Office Phone	Office Fax							

TREATMENT INFORMATION

Drug Requested:	Dose Requested:	
Reason for Use:		
ICD-9 Related to Use:	Duration of Disease:	
List other medication this patient has tried with this condition:		
Drug: _____	Regimen: _____	Dates of Therapy: _____ to _____
Drug: _____	Regimen: _____	Dates of Therapy: _____ to _____
Drug: _____	Regimen: _____	Dates of Therapy: _____ to _____

Does this patient have any co-morbid conditions that will affect therapy: Yes No
If so, please list: _____

I certify this information is correct. I understand that intentional misrepresentation of information herein may constitute fraud and be subject to legal action.

Recertification is required annually. _____ Physician Signature _____ Date

SUBMISSION INSTRUCTIONS

FAX

You may fax the signed and completed form to Pharmacy Review at:
205 220-9575

MAIL

You may mail the signed and completed form to:
Part D Authorization Requests
Attention : Pharmacy Review
P.O. Box 12485 • Birmingham Alabama 35202-2485