



**Physician's Prior Authorization Request**

**Patient:**

**ID#:**

**DOB:**

**Patient Address:**

**Drug Being Considered:** \_\_\_\_\_

Please complete the following questions and sign below. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the medical diagnosis of this patient? *(Please do not use codes.)* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

2. What other medications have been tried and not worked effectively? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

3. How long do you anticipate this treatment to last? \_\_\_\_\_

4. Will this medication be provided and administered in physician's office?  Yes  No

**Supporting medical documentation must be submitted.**

*Patient administered specialty drugs will be shipped to the patient by our Specialty Pharmacy.*

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please **Print** Physician's Name & Specialty

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at [www.usableadmin.com/providers/PharmacyForms.aspx](http://www.usableadmin.com/providers/PharmacyForms.aspx)