



## PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM

**\*\*Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPPA, as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment, and healthcare operations (TPO). HIPPA does not restrict the communication of PHI with providers for TPO related purposes.**

Date of Request \_\_\_\_\_

Case # \_\_\_\_\_

|                   |                  |
|-------------------|------------------|
| Patient Name      | D.O.B            |
| Employer Name     | TPC              |
| Physician Name    | DEA# / Specialty |
| Physician Phone # | Physician Fax #  |

Medication / Dose requested: \_\_\_\_\_ Diagnosis / ICD – 9 \_\_\_\_\_

### Reason for Request (Provide Clinical Rationale)

- Prior Authorization Required
- Quantity Limitation Exception
- Mandatory Generic Exception
- Mandatory Mail Exception
- Formulary Exception

Previous medications tried / failed and reason for failure: (List) \_\_\_\_\_

Other relevant patient information: \_\_\_\_\_

Would you like to be notified on approval/denial of this authorization? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Physician Signature:** \_\_\_\_\_

\*\*Physician signature field must be completed. Requests will not be reviewed in the event that this field is incomplete.

\*\*Please call 1-888-645-9303 for assistance in filling out this form. (Dr. office only). Most requests are processed within one business day of receiving complete information. However, some requests may require more time to review.

COMPLETED FORMS MAY BE FAXED TO (412) 967-2364

### FOR INTERNAL USE ONLY

**Approved** \_\_\_\_\_ **Denied** \_\_\_\_\_ **Date** \_\_\_\_\_