

Medication Prior Authorization Request Form

Your request cannot be processed without complete information. This includes provider specialty, NPI # and address

Member Name:	Provider Name:
Member ID:	Specialty:
Address:	Address:
Phone:	Phone:
Date of Birth:	Fax:
	NPI # (required)

Medication:	Strength:
Directions for Use:	
Diagnosis*:	
Date Patient Started Medication:	
Name of Specific Medications Tried and Failed:	
Reason For Non-Formulary Request (<i>Patient chart notes will be requested if further documentation is necessary</i>)	
Requesting Physician's Signature:	Date:
Additional Notes:	

To Prescriber – Complete ENTIRE form, SIGN and return to: Prescription Solutions
 Mail Stop CA-106-0286
 3515 Harbor Boulevard,
 Costa Mesa, CA 92626
Phone: 1.800.711.4555
Fax: 1.800.527.0531

***** Please call to expedite your request*****

***Prior Authorizations can now be requested via the Internet at www.rxsolutions.com*
 Go into the "Healthcare Professionals" section, under "Providers", select "Prior Auth Request Form"**