PARAMOUNT
Marketplace Coverage

Paramount Marketplace Only

Specialty Drug Prior Authorization Request Form

PHARMACY FAX # 844-256-2025

- Pertinent office notes, past medical history, past pharmacy history, lab results, test results, and supporting documentation **must** be submitted with the prior authorization request.
- Please call **1-800-891-2520** to **request a copy of drug or disease specific prior authorization criteria**.

PATIENT INFORMATION

Patient Name		Date
Paramount ID	DOB	Gender: M/F
Medication Allergies		
Pharmacy	Pharmacy Phone	

PROVIDER INFORMATION

Prescriber Name	NPI #	DEA #
Prescriber Specialty	Prescriber Address	
Office Fax	Phone	Office Contact Name

MEDICATION REQUESTED

Drug Name	Strength	Directions (Sig)	
Duration of Therapy: Days:_____Months: _____	Quantity	HBAIC w/Date (if applicable)	Diagnosis
Is the Patient currently being treated with this medication? ☐ Yes; Date started mm/dd/yy___/___/_____			☐ No

MEDICAL JUSTIFICATION: Include Other Relevant Medications Tried and Results

Please indicate previous treatment and outcomes below					
Previous Medication	Strength	Qty	Directions (Sig)	Dates (mmddyy to mmddyy)	Reason for Discontinuation
1					
2					
3					
4					
5					

RELEVANT MEDICAL RATIONALE FOR REQUEST/ADDITIONAL CLINICAL INFORMATION (Attach Relevant Lab Results and Chart Notes)*

Provider Signature	Date

In order to process this request, please complete all boxes completely.