

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 <u>must</u> 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.

1 2 3 4 5 RELEVANT MEDICAL RATIONALE FOR REQUEST/ADDITIONAL CLINICAL INFORMATION	Patient Name									Date	
Pharmacy Phone PROVIDER INFORMATION Prescriber Name	Paramount ID				DOB			Gender: M/F			
PROVIDER INFORMATION Prescriber Name NPI #	Medication Allergies										
Prescriber Name Prescriber Specialty Prescriber Address Office Fax Phone Office Contact Name MEDICATION REQUESTED Drug Name Strength Directions (Sig) Duration of Therapy: Days:Months: Better 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	Pharmacy				Pharmacy Phone						
Prescriber Name Prescriber Specialty Prescriber Specialty Prescriber Address Phone Office Contact Name MEDICATION REQUESTED Drug Name Strength Directions (Sig) Duration of Therapy: Days:Months: Busined Strength 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	PROVIDER INFORMATIO										
Office Fax Phone Office Contact Name MEDICATION REQUESTED Drug Name Strength Directions (Sig) Duration of Therapy: Days:Months: Is the Patient currently being treated with this medication? Test and Results Please indicate previous treatment and outcomes below Previous Medication Strength Qty Directions (Sig) Dates (mmddyy / /No Reason for Discontinuation 1 2 3 4 5 RELEVANT MEDICAL RATIONALE FOR REQUEST/ADDITIONAL CLINICAL INFORMATION					NPI# D				DEA#		
MEDICATION REQUESTED Drug Name Duration of Therapy: Days:Months: Quantity 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	Prescriber Specialty			Pres	Prescriber Address						
Drug Name Strength Directions (Sig)	Office Fax			Pho	Phone C				Office Contact Name		
Drug Name Strength Directions (Sig)	MEDIO ATION DEGLISOT										
Duration of Therapy:	· · · · · · · · · · · · · · · · · · ·	.D	Ctrong	th.		Directions (Cia)					
Days:Months:	Drug Name	Name		un	Directions (Sig)						
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 2 3 4 5 RELEVANT MEDICAL RATIONALE FOR REQUEST/ADDITIONAL CLINICAL INFORMATION		Quantity							Diagnosis		
Please indicate previous treatment and outcomes below Previous Medication Strength Qty Directions (Sig) Dates (mmddyy to mmddyy) Reason for Discontinuation 2 3 4 5 RELEVANT MEDICAL RATIONALE FOR REQUEST/ADDITIONAL CLINICAL INFORMATION	Is the Patient currently being	treated w	ith this r	nedica			arted mm/dd/y	y <u>/</u> /		□ No	
Previous Medication Strength Qty Directions (Sig) Dates (mmddyy to mmddyy) Reason for Discontinuation 2 3 4 5 RELEVANT MEDICAL RATIONALE FOR REQUEST/ADDITIONAL CLINICAL INFORMATION	MEDICAL JUSTIFICATION		e Othe	r Rel	evant l	Medications	Tried and F	Results			
Previous Medication Strength Qty Directions (Sig) Dates (mmddyy to mmddyy) Reason for Discontinuation 2	Please indicate previous treatment a	and outcome	s below								
2 3 4 5 RELEVANT MEDICAL RATIONALE FOR REQUEST/ADDITIONAL CLINICAL INFORMATION				Qty	Direc	ctions (Sig)	Dates (mmd	Dates (mmddyy to mmddyy)		Reason for Discontinuation	
3 4 5 RELEVANT MEDICAL RATIONALE FOR REQUEST/ADDITIONAL CLINICAL INFORMATION	1					-					
4 5 RELEVANT MEDICAL RATIONALE FOR REQUEST/ADDITIONAL CLINICAL INFORMATION	2										
5 RELEVANT MEDICAL RATIONALE FOR REQUEST/ADDITIONAL CLINICAL INFORMATION	3										
RELEVANT MEDICAL RATIONALE FOR REQUEST/ADDITIONAL CLINICAL INFORMATION	4										
	•										
	5	TIONAL	= FOR	REOL	IFST//	ADDITIONA	L CLINICAL	INFORMA	\TI	ON.	
	5 RELEVANT MEDICAL RA					ADDITIONA	L CLINICAL	INFORMA	ATI	ON	
	5 RELEVANT MEDICAL RA					ADDITIONA	L CLINICAL	INFORM <i>A</i>	ATIO	ON	
	5 RELEVANT MEDICAL RA					ADDITIONA	L CLINICAL	INFORM	ATI	ON	
	5 RELEVANT MEDICAL RA					ADDITIONA	L CLINICAL	INFORMA	ATI	ON	
	5 RELEVANT MEDICAL RA					ADDITIONA	L CLINICAL	INFORM	ATIO	ON	

^{*}In order to process this request, please complete all boxes completely.