FUTURE SCRIPTS

General Prior Authorization Form

DATE:

DRUG REQUESTED: _____	**QUANTITY REQUESTED/DAY:** _____

REQUEST TYPE:

☐ Gender Edit ☐ Quantity Edit ☐ Age Edit ☐ Prior Authorization

Patient's Name:	Prescribing Physician:
Date of Birth:	Provider NPI:
Patient ID:	Office Telephone:
Patient's Telephone Number:	Office Fax Number:
Patients Address	Office Address
City: State: ZIP:	City: State: ZIP:

1. **PROVIDER SPECIALTY** (specify all) _____

2. **DIAGNOSIS FOR DRUG REQUESTED** (specify all) _____

3. **MEDICATION HISTORY** (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

Drug Name (dose and frequency)	Duration of therapy (include dates)	Currently prescribed
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Please add any other supporting medical information that may be useful in the decision-making process including contraindications to medications related to the diagnosis:

_____

_____

_____

_____

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL