

# Medication Prior Authorization Request Form

*\*REQUIRED FIELDS: PA requests with missing/incomplete required fields may be returned as an invalid request. Valid requests also require appropriate clinical documentation to support the medical necessity of this request.*

Type of Request: \_\_\_\_\_

Today's Date: \_\_\_\_\_

I. MEMBER INFORMATION		II. PRESCRIBER INFORMATION	
<b>*Name:</b>		<b>*Name:</b>	
ID Number:		Specialty:	
Gender:		<b>*NPI or DEA Number:</b>	
<b>*Date of Birth:</b>		<b>*Phone:</b>	
Medication Allergies:		<b>*Fax:</b>	
Member's Height:		Office Contact Name:	
Member's Weight:                      kg              lb. (select one)			
III. ADMINISTRATION			
Site of Administration:		If other, specify:	
<b>If preferred administration site has a different address than the prescribing physician's practice above, please complete the following:</b>			
Name of Preferred Site of Administration or Home Infusion Company:			
Contact Name:	Phone:	Fax:	NPI#:
IV. DRUG INFORMATION (only ONE drug request per form)			
<b>*HCPCS (if buy and bill):</b>		<b>*Drug Name:</b>	
<b>*Strength:</b>		<b>*Dosage Form:</b>	
<b>*Directions for Use (sig):</b>			
<b>*Therapy Start Date:</b>		<b>*Therapy End Date:</b>	
V. DIAGNOSIS (as relevant to this request)			
Diagnosis:		<b>*ICD10:</b>	
Date of Diagnosis:		NOTE: Include diagnostic clinicals (labs, radiology, etc.).	
VI. RATIONALE FOR REQUEST and PERTINENT CLINICAL INFORMATION			
NOTE: Supporting documentation (such as office chart notes, lab results, prior therapy and other clinical information) is REQUIRED for consideration of approval.			

X \_\_\_\_\_  
Prescriber Signature

Date: \_\_\_\_\_

For a current listing of preferred products, visit [Ambetter.SunshineHealth.com](http://Ambetter.SunshineHealth.com) or contact Provider Services at 1-844-477-8313.