



**PRIOR AUTHORIZATION REQUEST FORM**  
EOC ID:

**Phone: 1-855-693-3921 Fax back to: 1-866-650-3622**

Retiree RxCare manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**Please note any information left blank or illegible may delay the review process.**

<p><b>Patient Name:</b></p> <p>Member Number: _____</p> <p>Date of Birth: _____</p> <p>Group Number: _____</p> <p>Address: _____</p> <p>City, state, ZIP: _____</p> <p>Member Phone: _____</p> <p>Drug name: _____</p> <p>Directions/SIG: _____</p>	<p><b>Prescriber Name:</b></p> <p>Fax: _____ Phone: _____</p> <p>Office Contact: _____</p> <p>NPI: _____ State Lic ID: _____</p> <p>Address: _____</p> <p>City, state, ZIP: _____</p> <p><input type="checkbox"/> Expedited/Urgent</p>
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Q1. What condition is being treated with this medication? \*

Q2. Is this request for initial or continuing therapy?

Initial

Continuing

Q3. For continuing therapy, please indicate the approximate start date (month/year)

Q4. Please provide any previous medications tried and failed for treating this patients condition.

Q5. Please provide any concurrent therapy this patient will be receiving with this medication

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**

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**Q6. Please submit any additional notes regarding treatment or off label usage for this medication that may be relevant for the approval of this medication.**

**Physician Signature**

**Date**

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