SPECIALTY and NON-SPECIALTY MEDICATION PRIOR AUTHORIZATION FORM

Please **fax** request to **954-302-8425** or mail to: **US-Rx Care,** 4600 Sheridan Street
Telephone: **844-744-4410** Suite 200, Hollywood, FL 33021

COMPLETE SUPPORTING MEDICAL RECORDS MUST ACCOMPANY THIS FORM TO COMPLETE THE PRIOR AUTHORIZATION REVIEW. NO, OR INCOMPLETE, SUPPORTING MEDICAL RECORDS WILL DELAY THE PRIOR AUTHORIZATION REVIEW PROCESS AND RESULT IN ADMINISTRATIVE DENIAL.

PROVIDER INFORMATION		MEMBER INFORMATION	
Prescriber name (print)		Member name (print)	Member Phone:
Prescriber Specialty	Prescriber NPI	Member ID	
Fax	Phone	Date of Birth	
Office Contact Name		Medication Allergies	

DRUG REQUEST

Drug name & strength	Dosage Form	Dosage Interval (sig)	Qty/day
Diagnosis relevant to this request		Expected length of therapy	

MEDICATION HISTORY FOR THIS DIAGNOSIS

A. Is patient currently on this medication? Yes Date Started: No

B. Is this request for continuation of a previous approval? (Exclude Drug Samples) Yes No

C. Has strength, dosage, or quantity required increase or decrease? Yes What changed? No

D. Please indicate previous treatments and outcomes below:

Drug name (strength & dosage)	Dates of therapy	Reason for discontinuation
1		
2		
3		
4		

NOTE: Confirmation of use will be made from the member history file; prior use of preferred drugs is part of the exception criteria.
Website: www.USRxCare.com

Rational for request/ Pertinent Clinical Information (required for all prior authorizations, fax patient history)

Weight	Height	Diagnosis	ICD-10

Has patient received injection training? Yes If yes, Date: No

Additional:

***Please list current servicing provider (facility or pharmacy/location):_____

****Form must be completed to process** Please attach pertinent medical records for the member's condition including documentation for past medication history.**

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider signature	Date

US-Rx Care will respond via fax or phone within 72 hours of receiving all necessary information, excluding weekends and holidays. Request for prior authorization (PA) must include the member name, insurance, ID#, date of birth, and drug name. **Incomplete forms may delay processing.** Please include lab reports with request when appropriate (e.g., C&S, HgA1C, Serum Cr, CD4, H&H, WBC, etc.). Additional drug-specific information may be requested.