MEDICATION PRIOR AUTHORIZATION FORM

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

US-Rx Care
https://usrxcare.com/providers
Tel: 844-744-4410

COMPLETE SUPPORTING MEDICAL RECORDS MUST ACCOMPANY THIS FORM TO COMPLETE THE PRIOR AUTHORIZATION REVIEW. MISSING OR INCOMPLETE SUPPORTING MEDICAL RECORDS WILL DELAY THE PRIOR AUTHORIZATION REVIEW PROCESS AND RESULT IN ADMINISTRATIVE DENIAL.

PROVIDER INFORMATION		MEMBER INFORMATION	
Prescriber Name:		Member Name:	Member Phone:
Prescriber Specialty:	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 and ICD-10 (When Necessary):	Expected Length of Therapy:	
Is patient currently on this medication? Yes / No	If Yes, Date Started:	
Is this request for continuation of a previous approval (excluding drug samples)? Yes / No		

RATIONALE FOR REQUEST/PERTINENT CLINICAL INFORMATION (Please be sure to fax patient history and supporting documentation.)	
Weight:	Height:
Current Servicing Provider (Facility or Pharmacy/Location):	
Additional Information:	
Provider Signature	Date

FORM MUST BE COMPLETED IN FULL TO PROCESS YOUR REQUEST

US-Rx Care will respond via fax or phone within 72 hours, excluding weekends and holidays, of receiving all necessary information. **Incomplete forms may delay processing.** Please include lab reports with request when appropriate. Additional drug-specific information may be requested.