

PRIOR AUTHORIZATION FORM - PRESCRIPTION DRUG

Please fax the completed form to 888-219-0180.

*For GLP-1s, please use the InScript GLP-1 Prior Authorization Form. For all other drugs, please use this form.

To access PA forms online, please visit: https://paforms.com/inscript/

For inquiries regarding PA status and submission:

- Members/providers/pharmacies may contact 855-542-1819.
- Providers/pharmacies may contact 866-521-2323. Member calls will not be accepted.

INSTRUCTIONS: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data) to support the prior authorization request.

or safety of the men	nber or others,	due to the member	s psycho	ological state, or in	the opinio	on of a pra	ly jeopardize the life, ctitioner with knowle	edge of	
the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.									
Patient Information: This must be filled out completely to ensure HIPAA compliance.									
First Name: Last Name:			MI		Phone	one Number:			
Address:			City:		1	State:	Zip Code:		
Date of Birth:	☐ Male ☐ Female	Height (in/cm Weight (lb/kg					-		
Patient's Authorized Representative (if applicable):				Authorized Representative Phone Number:					
Insurance Information									
Primary Insurance Name:				Patient ID Numb	Patient ID Number:				
Secondary Insurance Name:				Patient ID Number:					
Prescriber Information									
First Name: Last Name:				Specialty:					
Address:			City		State: Zip Code:				
Requester (if different than prescriber):				Office Contact P	Office Contact Person:				
NPI Number (individual):				Phone Number:					
DEA Number (if required):				Fax Number (in HIPAA compliant area):					
E-mail Address:									
Medication/Medical and Dispensing Information									
Medication Name: Generic substitution permitted *If neither box is checked, PA Logic will review as "generic substitution permitted".									
☐ New Therapy ☐ Renewal If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):									
Pharmacy Name: Pharmacy Fax Number: Pharmacy Fax Number:									
Dose/Strength:		Frequency:		Length of Thera		1	uantity/Day Supply: /	days	



Administration: Oral/SL Topical Injection IV Other Administration Location: Physician's Office Ambulatory Infusion Center Outpatient Hospital Care Other Other Other Care Agency Other (explain):								
 Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review (e.g. chart notes or lab data) to support the prior authorization request. 1. Has the patient tried any other medications for this condition? 								
Medication/Therapy (Specify Drug Name and Dosage)	Duration of Therapy (Specify Dates)	Response/Reason for Failure/Allergy						
2. List Diagnoses:		ICD-10:						
3. Required clinical information – Please provide all relevant clinical information to support a prior authorization review. • PLEASE ATTACH documentation of: • Symptoms • Lab results with dates to establish diagnosis or evaluate response • Justification for initial or ongoing therapy or increased dose • If patient has any contraindications for the health plan/insurer preferred drug(s) • Any additional clinical information or comments pertinent to this request for coverage (e.g., formulary tier exceptions) or required under state and federal laws. Please use the section below to describe any additional points for consideration.								
Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.								
Prescriber Signature: Date:								

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