



PHARMACY SERVICES
Prior Authorization
(PA) Request Form
PHONE (888) 361-1610
FAX (800) 207-8235
www.odscompanies.com

DATE: December 15, 2010

SENDER'S INITIALS: _____

PATIENT INFORMATION

ENROLLEE NAME: _____ DATE OF BIRTH: _____

SUBSCRIBER ID #: _____ GROUP #: _____

PHYSICIAN INFORMATION

NAME: _____

PHONE: _____ FAX: _____

CONTACT NAME: _____

MEDICATION INFORMATION

MEDICATION NAME AND STRENGTH: _____

FREQUENCY: _____ ICD-9 CODE: _____

MEDICATIONS PREVIOUSLY TRIED BY THE PATIENT:

MEDICATION NAME AND STRENGTH	DATES USED (APPROXIMATE)	DOCUMENTATION OF TREATMENT FAILURE

CIRCUMSTANCES FOR MEDICAL NECESSITY: _____

INTERNAL USE ONLY

DATE OF RECEIPT: _____ DATE OF REVIEW: _____ PAC: _____

REASON FOR CLINICAL REVIEW: DOES NOT MEET CRITERIA STEP-THERAPY NOT MET

EXCEEDS QLL OF ___ PER ___ DAY SUPPLY DAW DIFFERENCE EXCEPTION

OTHER: _____

APPROVED: _____ DENIED: _____ REASON: _____

REVIEWER'S SIGNATURE: _____ DATE: _____