



Medicare Part D Clinical Prior Authorization Fax Form

Date: _____ Initiator Name: _____

Initiator Phone #: () _____ Initiator Fax #: () _____

As the initiator, are you: the PATIENT, the PHYSICIAN'S OFFICE, or the PHARMACY? (please circle one)

A - Patient Information

Patient Last Name: _____ Patient First Name: _____

Cardholder ID #: _____ Group #: _____

Patient Phone #: _____ Patient Date of Birth: _____

Mailing Address: _____

B - Drug Information

Drug Name: _____ Fill Date: _____

Qty: _____ Drug Strength: _____ Directions: _____

Reason for PA: _____

C - Physician Information

Physician Name: _____

Physician Phone #: () _____ Physician Fax #: () _____

D - Pharmacy Information

Pharmacy Name: _____ Pharmacy NCPDP#: _____

Pharmacy Phone #: () _____ (Ext) _____ Fax #: () _____

Contact Person: _____

CONFIDENTIAL HEALTH INFORMATION:

Health care information is personal information related to a person's health care.

It is being sent to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without appropriate customer/patient authorization or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.

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