Core Management Resources

– Prescription Drug Prior Authorization Form –

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information. *Additional information may be requested*.

☐ **STANDARD REVIEW (48 HOURS)** ☐ **EXPEDITED REVIEW (SAME DAY)**

PATIENT INFORMATION			
Patient Name:		Plan Name:	
ID#:	DOB:	Gender: ☐ Male ☐ Female	Patient Phone #:
PROVIDER INFORMATION			
Provider Name:		Specialty:	DEA or TIN:
Address:			
Office Contact Person:		Office Phone:	Office Fax:
DRUG INFORMATION			
Requested Drug Name/Strength:		Quantity:	# Refills
☐ New Prescription –OR– Date Therapy Initiated / /	Frequency of Dosing:		Expected Length of Therapy:
CLINICAL INFORMATION			
Diagnosis Related to Medication Requested:	Height and Weight:		Drug Allergies:
☐ Complex patient with two or more chronic conditions Stability of patient's current condition:		Any high risk indicators?	
Alternative therapies tried [include drug name, result of adverse outcome (e.g. toxicity, allergy or therapeutic failure), and dose/duration of therapy of each drug]: 1. 2. 3.			
Provide the medical rationale for requested drug (indicate expected clinical outcome; include chart notes, supporting labs, etc.)			
Provider's Signature:			Date:

When completed please return to:

Core Administrative Services
PO Box 90
Macon, GA 31202-0090
478-741-3521 / 888-741-2673
FAX: 478-745-1843