



## 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: <input type="checkbox"/> Male <input type="checkbox"/> 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
<input type="checkbox"/> 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:	
<input type="checkbox"/> 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

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