Retiree RxCare

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Phone: 1-855-693-3921 Fax back to: 1-866-650-3622

Retiree RxCare manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

Please note any information left blank or illegible may delay the review process.

Patient Name:	**Prescriber Name:**
Member Number: _____	Fax: _____ Phone: _____
Date of Birth: _____	Office Contact:_____
Group Number: _____	NPI:_____ State Lic ID:_____
Address: _____	Address:_____
City, state, ZIP: _____	City, state, ZIP: _____
Member Phone: _____	
Drug name: _____	¨ Expedited/Urgent
Directions/SIG: _____	

Q1. What condition is being treated with this medication? *
Q2. Is this request for initial or continuing therapy? ☐ Initial ☐ Continuing
Q3. For continuing therapy, please indicate the approximate start date (month/year)
Q4. Please provide any previous medications tried and failed for treating this patients condition.
Q5. Please provide any concurrent therapy this patient will be receiving with this medication

_____ _____

Physician Signature **Date**

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Phone: 1-800-580-4403 Fax back to: 1-866-650-3622

AmWINS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

Please note any information left blank or illegible may delay the review process.

Q6. Please submit any additional notes regarding treatment or off label usage for this medication that may be relevant for the approval of this medication.

_____ _____

Physician Signature **Date**