



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? <input type="checkbox"/> Initial <input type="checkbox"/> 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

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document.

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

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document.