



## PRIOR AUTHORIZATION FORM

**PLEASE FAX COMPLETED FORM TO: (800) 639-9158**

<b>Patient Name:</b>	<b>Member ID #</b>
<b>Date of Request:</b>	<b>DOB:</b>
<b>Requesting Physician:</b>	<b>DEA #</b>
<b>Office Phone #</b>	<b>Office Fax #</b>

### ***MEDICATION INFORMATION***

<b>1. Drug Requested:</b> <i>(Please include: dose/frequency/length of therapy.)</i>
<b>2. If Injectable medication, where is it being administered?</b> <input type="checkbox"/> Home (self-administered) <input type="checkbox"/> Office administered
<b>3. Diagnosis:</b> <i>(Please include all office notes supporting diagnosis.)</i>
<b>4. Previous agents tried:</b> <i>(Include all office notes and supporting documentation.)</i> Drug:    Date(s) used:    Outcome:  Drug:    Date(s) used:    Outcome:  Drug:    Date(s) used:    Outcome:  Drug:    Date(s) used:    Outcome:
<b>5. Other Supporting information:</b>
<b>Physician's Signature:</b>
<b>Physician's Specialty:</b>

CHCH 2007-1(11/07)

**For Urgent Requests please call (800) 551-2694**

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