PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Phone: 800-687-0707 Fax back to: 844-370-6203

MaxorPlus manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescriber. 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/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Address:	NPI: State Lic ID:
City, State ZIP: ,	Address:
Primary Phone:	City, State ZIP: ,

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign. – A request should only be deemed urgent when the prescriber believes the member's health, life or ability to regain maximum function may be seriously jeopardized under the standard review timeframe.

Drug Name: Expedited/Urgent ☐

Q1. Please confirm the fill history for this specific medication: ☐ New Start/Initial Fill ☐ Renewal/Continuation of Therapy
Q2. If this is a Renewal/Continuation of Therapy, please confirm the initial start date and how the medication was obtained (via insurance, samples, etc).
Q3. Dosage and Directions for Use:
Q4. Quantity Requested:
Q5. Anticipated duration of therapy:
Q6. What is the patient's diagnosis (please include ICD-10 codes)?
Q7. Prior alternative treatment(s) provided for this condition:
Q8. Required Supporting Clinical Statement (such as protocols or evidence based guidelines followed, concurrent therapies, comorbidities, outcomes of previous drugs and therapies used, etc.):
Q9. Relevant Lab Values:

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date