

PRIOR AUTHORIZATION REQUEST - INJECTABLE MEDICATION

Please complete all applicable fields in this form. Fax the completed form to Pharmacy Services at 877-232-5976.

PATIENT INFORMATION

Patient name: _____

Patient ID: _____

Date of birth (MM/DD/YY): _____

Gender: Male Female

PRESCRIBER INFORMATION

Physician name: _____

Specialty: _____

Phone: _____

Fax: _____

Contact person: _____

AUTHORIZATION INFORMATION

Diagnosis: _____

Diagnosis code: _____

Referring physician: _____

Medication and dose requested	Start/end dates of service	J-Code/HCPCS codes*	Number of visits

MEDICAL RATIONALE FOR USE**

SPECIAL CONSIDERATIONS

Prescriber Signature _____

Date _____

*Please ensure that the correct J-Code is used. This will expedite processing for your request.

**If medication/therapy prescribed requires prior authorization, provide rationale for use.



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