



Medication Prior Authorization Form

Fax back to: 1-877-577-9045 Phone: 1-877-577-0115

Email: rxauth@clearhealthalliance.com

Member Information

Last Name: _____ First Name: _____ D.O. B: _____

ID Number: _____

Standard Expedited* By checking this box I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Prescriber Information

Name: _____ NPI: _____ Specialty: _____

Phone Number: _____ Fax number: _____

Medication Requested: (Please include name, strength, quantity and directions): _____

Estimated duration of therapy: _____

Diagnosis and pertinent clinical information: _____

Previous medications tried for this diagnosis and when _____

Outcome of previous treatment and/or reason for intolerance to the formulary medication: _____

Duration of treatment with previous medication: _____

IF THIS IS A REQUEST FOR REAUTHORIZATION of a previously approved requested, please provide recent clinical documentation

♦Please complete **all sections** legibly. Authorization decisions are completed within 24 hours of receipt of all requested information unless you indicate this is an urgent request and the request meets urgent criteria

♦PLEASE fax all pertinent clinical documentation and your prescription with this completed form. Any information left blank or illegible may delay the review process.

Physician Signature

Date

FOR CLEAR HEALTH PLAN USE ONLY

Approved _____ Duration _____ Denied _____ Pending _____
Addtl. Information request on _____ at _____ AM _____ PM Spoke to _____

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