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** _____