Reset Form Print Form

Prescription Drug Prior Authorization Form

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization or step-therapy exception request [CA ONLY]). **Information contained in this form is Protected Health Information under HIPAA.**

☐ **NON-URGENT** ☐ **EXIGENT CIRCUMSTANCES**

Member Information

LAST NAME: **FIRST NAME:**

PHONE NUMBER: – – **DATE OF BIRTH:** – –

STREET ADDRESS:

CITY: **STATE:** **ZIP CODE:**

☐ **MALE** ☐ **FEMALE** **HEIGHT** (in/cm): _____ **WEIGHT** (lb/kg): _____ **ALLERGIES:** _____

If you are not the patient or the prescriber, you will need to submit a PHI Disclosure Authorization form with this request which can be found at the following link: www.cap-rx.com

PATIENTS' AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE PHONE NUMBER:

– –

Insurance Information

PRIMARY INSURANCE NAME: **PATIENT ID NUMBER:**

SECONDARY INSURANCE NAME: **PATIENT ID NUMBER:**

Prescriber Information

LAST NAME: **FIRST NAME:**

PRESCRIBER SPECIALTY: **E-MAIL ADDRESS:**

NPI NUMBER: **DEA NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – – –

STREET ADDRESS:

CITY: **STATE:** **ZIP CODE:**

REQUESTOR (if different than Prescriber)**:** **OFFICE CONTACT PERSON:**

Continued on next page.

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MEMBER'S LAST NAME: | | | | | | | | | | | | |

MEMBER'S FIRST NAME: | | | | | | | | | | | | |

Medication / Medical and Dispensing Information

Medication Name:

Dose/Strength:	**Frequency:**	**Length of Therapy/#Refills:**	**Quantity:**

☐ New Therapy ☐ Renewal ☐ Step Therapy Exception Request (CA ONLY)
If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

How did the patient receive the medication?
☐ Paid under Insurance Name:_____ Prior Auth Number (if known):_____
☐ Other (explain):

Administration:
☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:

Administration Location:
☐ Physician's Office ☐ Patient's Home ☐ Long Term Care
☐ Ambulatory Infusion Center ☐ Home Care Agency ☐ Other (explain):_____
☐ Outpatient Hospital Care

1. Has the patient tried any other medications for this condition? ☐ **YES (if yes, complete below)** ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses: **ICD-10:**

3. REQUIRED CLINICAL INFORMATION – Please provide all relevant clinical information to support a prior authorization or step therapy exception request review (CA ONLY).

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the health plan/insurer preferred drug. Lab results with dates must be provided if needed to establish diagnosis, or evaluate response. Please provide any additional clinical information or comments pertinent to this request for coverage, including information related to exigent circumstances, or required under state and federal laws.

☐ **Attachments**

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

Fax This Form to: 833-434-0563

Mail requests to:
Capital Rx
Attn: Prior Authorization
228 Park Ave S, Suite 87234, New York, NY 10003
888-95CAPRX (888-952-2779)