This form can be filled out on screen and then printed. Click RESET to clear all fields.

Reset

ARIZONA

Standardized Prior Authorization Request For Medication, DME, and Medical Device

Medica

Fax to **(952)-992-2836** or email to **ifbhealthmanagement@Medica.com** or U.S. Mail to Medica Utilization Management Department, PO Box 9310 Route CP440, Minneapolis, MN 55440-9310

SECTION 1 : SUBMISSION

Subscriber name:	Phone:	Fax:	Date:

SECTION 2 : REASON FOR REQUEST

Check one:	❍ Initial request	❍ Continuation/renewal request
Reason for request: (check all that apply)		❍ Prior authorization
❍ Step therapy, formulary exception		❍ Medical device
❍ Quantity exception		❍ Durable medical equipment (DME)
❍ Specialty drug		❍ Other (*please specify*)_____

SECTION 3 : REVIEW

❍ **Expedited/urgent review requested:** By checking this box and signing below, 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.

Signature of prescriber or prescriber's designee: _____

SECTION 4 : PATIENT INFORMATION

Name:	Phone:	DOB:	❍ Male ❍ Female
Address:	City:	State:	ZIP code:
Subscriber name (if different from Section 1):	Member ID #:	Group name or number:	
BIN # (if available):	PCN (if available):	Rx ID # (if available):	

SECTION 5 : PRESCRIBER/ORDERING PROVIDER INFORMATION

Name:		NPI #:	Specialty:
Address:		City:	State: ZIP code:
Phone:	Fax:	Office contact name:	Contact phone:

SECTION 6 : PRESCRIPTION DRUG INFORMATION

(*IF THIS IS A COMPOUND DRUG, IDENTIFY ALL INGREDIENTS IN SECTION 7, BELOW.*)

Requested drug name:				
Strength:	Route of administration:	Quantity:	Days' supply:	Expected therapy duration:

To the best of your knowledge this medication is:

❍ New therapy ❍ Continuation of therapy (approximate date therapy initiated: _____)

For provider administered drugs only:

HCPCS code: _____ NDC #: _____ Dose per administration: _____

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SECTION 7 : PRESCRIPTION COMPOUND DRUG INFORMATION

Compound drug name:					
Ingredient	NDC #	Quantity	Ingredient	NDC #	Quantity

SECTION 8 : PRESCRIPTION DME OR MEDICAL DEVICE INFORMATION

Requested DME or Medical device name:	Expected duration of use:	HCPCS code (if applicable):

SECTION 9 : PATIENT CLINICAL INFORMATION

Patient's diagnosis related to this request:	ICD version:	ICD code:
Patient's diagnosis related to this request:	ICD version:	ICD code:

Drugs patient has taken for this diagnosis: (*Provide the following information to the best of your knowledge*)

Drug name	Strength	Frequency	Dates started and stopped or approximate duration	Describe response, reason for failure, or allergy

Drug allergies:	Height (if applicable):	Weight (if applicable):

Relevant laboratory values and dates (attach or list below):

Date	Test	Value

SECTION 10 : JUSTIFICATION (PROVIDE OR ATTACH ANY ADDITIONAL JUSTIFICATION HERE: NOTES, TREATMENT PLANS, LAB/TEST RESULTS, ETC)
