PHARMACY ADVANTAGE
Specialty Pharmacy

Medication Request Form

☐ **Check here if the request is considered "Urgent"**

Phone: (800) 456 - 2112 **Fax: (888) 400 - 0109**

Checking URGENT certifies that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain max functionality

Patient Information

** Please include a copy of the front & back of all insurance cards**

Name:	**DOB:**	**Gender:**	**Allergies:**
Address:	**City:**	**State:**	**Zip:**
Phone #:	**Insurance Plan:**	**Insurance ID:**	
Patient Weight:	**Rx Group #:**	**Rx Bin #:**	**Rx PCN:**

Prescription Selection

Medication	Directions	Quantity	Refills
☐ New Therapy ☐ Continuing Therapy	Diagnosis/ICD-10:		
☐ New Therapy ☐ Continuing Therapy	Diagnosis/ICD-10:		
☐ New Therapy ☐ Continuing Therapy	Diagnosis/ICD-10:		
☐ New Therapy ☐ Continuing Therapy	Diagnosis/ICD-10:		
☐ New Therapy ☐ Continuing Therapy	Diagnosis/ICD-10:		

Clinical Information

Please submit the most recent Prescriber Notes, Lab/test results, and Prescriptions

Please **attach** or **describe** any other information related to this request:

Medication(s) Failed	Discontinuation Reason	Therapy Duration

Prescriber Information

Name:		**Specialty:**	
DEA:	**NPI:**		
Address:	**City:**	**State:**	**Zip:**
Phone #:	**Fax #:**	**Office Contact:**	**Ext:**

I certify that the above information is true and accurate to the best of my knowledge. I authorize Pharmacy Advantage Specialty Pharmacy and its representatives to act as an agent to initiate and complete insurance prior authorizations.

Prescriber Signature: _____ **Date:** _____ / _____ / _____

Requester Signature: **Date:**