



PRESCRIPTION PRIOR AUTHORIZATION REQUEST FORM

PLEASE FAX COMPLETED FORM TO 855-336-6612

URGENT Review **Standard Review**

In order to process your request as quickly as possible, all sections of the form must be completed legibly, and you must include relevant chart notes and/or labs as applicable. Our Medication Policies are available for your review at www.ventegra.com/medicationPolicies.aspx (not applicable for Mosaic Life Care).

Patient Information

Name	<input type="text"/>	Date of Birth	<input type="text"/>	Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Plan Name	<input type="text"/>	Member ID	<input type="text"/>			
Address	<input type="text"/>		Phone	<input type="text"/>		
Medication Allergies	<input type="text"/>					

Prescriber Information

Prescriber Name	<input type="text"/>				
Specialty	<input type="text"/>	NPI	<input type="text"/>		
Phone	<input type="text"/>	Fax	<input type="text"/>		
Form Completed by	<input type="text"/>				

Medication Information

Drug Name	<input type="text"/>	Strength	<input type="text"/>	Quantity	<input type="text"/>
Is the patient currently being treated with this medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If "Yes" for how long?	<input type="text"/>	
Diagnosis	<input type="text"/>	Instructions for Use	<input type="text"/>		

Clinical Information

Medication(s) previously tried and failed for this patient.		
Drug Name and Dosage	Duration of Therapy (specify dates)	Response / Reason for Failure / Allergy
<input type="text"/>	<input type="text"/>	<input type="text"/>

Please list and attach supporting labs or other test results:

Other information prescriber believes is important for review of this request:

Prescriber Signature: _____ Date: _____
By signature, the prescriber (or agent of the prescriber) confirms that all information provided is accurate.