



**GENERAL PRESCRIPTION DRUG  
COVERAGE AUTHORIZATION REQUEST FORM**

**GENERAL INFORMATION** *Request Type (please check one)*

Prior Authorization     Step Therapy Exception     Request for Quantity Limit Exception     Appeal     Mandatory Generic Exception

Patient Name		Date of Birth (mm/dd/yyyy)											
Patient's Home Address		<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>											
City	State	Zip											
		Contract Number (include prefix)											
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**PHYSICIAN INFORMATION**

Physician Name		Practice Type											
Practice Address		<input type="checkbox"/> PCP <input type="checkbox"/> Specialty: _____											
City	State	Zip											
		Physician NPI											
		<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>											
Office Phone	Office Fax												
	Provider Number												
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**REQUEST TYPE** *(please check one)*

Initial Authorization     Authorization Renewal    (Please attach any additional medical information.)

**TREATMENT INFORMATION**

Drug/Strength/Frequency/Quantity Requested: \_\_\_\_\_

Diagnosis/ ICD-9 Codes: \_\_\_\_\_    Duration of Disease (yrs): \_\_\_\_\_

Medical rationale for use (include chart notes if possible): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List medications this patient has tried for this condition (include current medications and titration history if applicable)

Drug	Strength/Frequency	Dates of Therapy	Outcome of Therapy
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Does this patient have any co-morbid conditions that will affect therapy:  Yes  No

If so, please list: \_\_\_\_\_

I certify this information is complete and correct to the best of my knowledge.

\_\_\_\_\_    \_\_\_\_\_

Physician Signature    Date

**Please attach any additional medical justification**

**SUBMISSION  
INSTRUCTIONS**

MKT-148 (Rev. 4-2008)

**FAX**

You may fax the signed and completed form to Pharmacy Review at:  
**866 606-6021**

**MAIL**

You may mail the signed and completed form to:  
**Pharmacy Review  
Post Office Box 3210  
Auburn, AL 36831**