

4D

REQUEST FOR PRIOR AUTHORIZATION
(ALL AUTHORIZATIONS ARE PENDING VALID ELIGIBILITY)

PRESCRIBING PHYSICIAN:

BENEFICIARY:

Name: _____

Name: _____

First Last

First Last

Direct Phone #: (____) - ____ - _____

Subscriber ID #: _____

Fax #: (____) - ____ - _____

Date of Birth: __-__-____

Physician specialty: _____

Sex: [] Female [] Male

Name and title of person completing form (please print): _____

Drug name: Strength: Administration Schedule: Length of Therapy: Quantity Requested:

a) _____

b) _____

c) _____

Patient's diagnosis for use of this medication: _____

1. Previous history of a medical condition, allergies or other pertinent medical information, that necessitates the use of this medication:

2. Has the patient been seen by any other provider for this condition? [] Yes [] No
If so, what was the prescriber's specialty? _____

3. Previous non-prior authorized and prior authorized medications tried and failed for this condition:

Table with 3 columns: Name of medication, Reason for failure, Date. Includes three rows of blank lines for data entry.

4. Pertinent laboratory test or procedure: (if applicable)

Table with 3 columns: Procedure, Findings, Date. Includes three rows of blank lines for data entry.

5. Other Information:

Submit Requests to:

4-D Pharmacy Management Systems
P.O. Box 721098
Berkley, Michigan 48072
Phone: (248) 540-6686 Fax: (248) 540-9811

DT REC: _____ TIME REC: _____
GCN: a) _____ b) _____ c) _____
EC: a) _____ b) _____ c) _____
Qty: a) _____ b) _____ c) _____
Appd :a) _____ b) _____ c) _____
R.Ph: _____ DATE: _____
Entrd by: _____ DATE: _____
Auth # a) _____
b) _____
c) _____

4D PA COMMENTS: _____

