SPECIALTY MEDICATION PRIOR AUTHORIZATION FORM

Please **fax request to **888-389-9668** or mail to: **US-Rx Care,** 6412 N. University Dr. #113, Tamarac FL**
Telephone: 754-800-7992

PROVIDER INFORMATION		MEMBER INFORMATION
Prescriber name (print)		Member name (print)
Prescriber Specialty		Member ID
Fax	Phone	Date of Birth
Office Contact Name		Medication Allergies

DRUG REQUEST

Drug name & strength	Dosage Form	Dosage Interval (sig)	Qty/day
Diagnosis relevant to this request		Expected length of therapy	

MEDICATION HISTORY FOR THIS DIAGNOSIS

A. Is patient currently on this medication	Yes	No
B. Is this request for continuation of a previous approval?	Yes	No
C. Has strength, dosage, or quantity required increase or decrease?	Yes	No
D. Please indicate previous treatments and outcomes below:		

Drug name (strength & dosage)	Dates of therapy	Reason for discontinuation
1		
2		
3		
4		

NOTE: Confirmation of use will be made from the member history file; prior use of preferred drugs is part of the exception criteria. US-Rx Care Preferred Drug List is available on website: www.USRxCare.com or call 754-800-7992

Rational for request/ Pertinent Clinical Information (required for all prior authorizations, fax patient history)

Weight	Height	Diagnosis	ICD-9

Has patient received injection training? Yes No If yes, Date:

Additional:

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider signature	Date

US-Rx Care will respond via fax or phone within 72 hours of receiving all necessary information, except during the weekends and holidays. Request for prior authorization (PA) must include the member name, ID#, DOB, and Drug Name. Incomplete forms may delay processing. Please include lab reports with request when appropriate (e.g., C&S, HgA1C, Serum Cr, CD4, H&H, WBC, etc.). Biopharmaceutical products may require additional information, to be requested as needed, and/or may be offered through the patient's medical benefits.