PRIOR AUTHORIZATION FORM
PHYSICIAN FAX FORM

Forms submitted without progress notes and labs will be denied for lack of information.

Patient Information			
Member ID:	Patient DOB:		
Patient First Name:	Patient Last Name:		
Address:	City:	State:	Zip:

Diagnosis and Medical Information		
Medication Requested:	Directions:	Quantity per Month:
Patient's Diagnosis (ICD-9 code plus description):		
Expected Length of Therapy:	Drug Allergies:	

Prescriber Information			
Prescriber Name:	NPI:	Contact Name:	
Office Telephone:	Office Fax:		
Address:	City:	State:	Zip:
Prescriber Signature:	Specialty:	Date:	

Fax Confidentiality Notice: If you experience trouble with this transmission, please call the number above immediately. The information contained in this facsimile message is legally privileged and is confidential information intended only for use by the individual or entity named above. If you have received this facsimile in error, please immediately notify us by telephone and return the original facsimile to us by mail.

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Chart Notes		
Is patient currently treated with this medication?	Yes	No
If yes, when was treatment with the requested medication started (please include medication history logs, showing prescribing dates)?		
Please list all reasons for selecting the requested medication over other alternatives (e.g. contraindications, allergies, history of adverse drug reactions to alternatives).		

Past Failures and Documentation of Reason for Past Failures		
Trial #1		
Drug name, strength, and sig:	Therapy Start Date:	Discontinue Date:
Reason for Discontinuation:		
Trial #2		
Drug name, strength, and sig:	Therapy Start Date:	Discontinue Date:
Reason for Discontinuation:		
Trial #3		
Drug name, strength, and sig:	Therapy Start Date:	Discontinue Date:
Reason for Discontinuation:		

Please mail or fax this form to:	**Instructions:**
WellDyneRx: Prior Authorizations Department P.O. Box 90369 Lakeland, FL 33804-0369 Phone: 1-866-240-2204 Fax: 1-888-473-7875	This form is to be used by participating providers to obtain coverage for a formulary drug requiring prior authorization (PA); a non-formulary drug for which there is no suitable alternative available, or any overrides of step therapy; quantity limits; or other edits. Please complete this form and fax to WellDyneRx at: 1-888-473-7875

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