Allied Benefit Systems

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Phone: 800-288-2078
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Retail Pharmacy Prior Authorization Request Form

All relevant information must be completed. Allied's receipt of this completed form does not constitute a guarantee of benefits.

When submitting a prior authorization request, please note the following information is necessary when applying criteria and determining medical necessity:

- Copy of the Rx Order or Script.
- 3-6 months clinical information.
- The member's current signs/symptoms or chief complaints as well as the duration of the symptoms.
- Medical history and physical exams along with the MOST current physician's progress notes.
- Current medications as well as medications that were TRIED/FAILED including ESI, Steroid/Hormone injections.
- Submit any imaging studies such as U/S reports, x-rays, CTs, if applicable to request.
- Submit any Lab Work such as fecal occult blood test/culture. reports/Hematocrit/Hemoglobin/Hormone studies/TSHs.

Today's Date:	**Date Medication Needed:**
Provider Office Contact Name:	**Provider Contact Phone Number:**

SECTION A PATIENT INFORMATION	
Patient First Name:	**Patient Last Name:**
Is Patient Currently Hospitalized?	
Is This Provider Going to Buy and Bill the Medication?	
If Yes Ship & Bill Authorization Contact Name:	
Shipping Contact Phone Number:	
If Patient Requires Medication Shipment - Please complete Sections B, C and D fully before returning this form. All required sections must be completed in full to ensure covered prescriptions ship within 3-7 business days. If these sections are not completed accurately, the order may be delayed.	

SECTION B INSURANCE INFORMATION	
Allied Group #:	
Subscriber Policy/Unique Identification Number:	
Employer Name:	
Subscriber First Name:	
Subscriber Last Name:	
Subscriber Address:	
Pharmacy Benefit Manager:	
Primary Insurance Company Name:	
Medicare or Medicaid? *Yes or No*	
Secondary Insurance? *Yes or No*	

SECTION C PHYSICIAN INFORMATION	
Prescribing Physician First and Last Name:	
Physician Address:	
Physician Phone:	
Physician Fax:	
Physician NPI Number: (or DEA/UPIN)	

SECTION D CURRENT MEDICAL INFORMATION	
Primary Diagnosis and ICD10 Code:	
Secondary Diagnosis and ICD10 Code:	
Medication Name:	
HCPCS/CPT Code:	
Strength:	
Quantity:	
# of Refills:	
Directions:	
Authorization Number: (if required)	

Administration Site: (*select one)*

☐ Physician's Office ☐ Patient's Home ☐ Home Care Agency ☐ Ambulatory Infusion Center

Shipping To: *(select one)*

☐ Physician's Office ☐ Patient's Home ☐ Home Care Agency ☐ Ambulatory Infusion Center

Include Name and Complete Address of Shipping Location	

_____ _____

Prescriber's Signature (required by law) Date