Retail Pharmacy Prior Authorization Request Form

Allied Benefit Systems
P.O. Box 211651
Eagan, MN 55121

P Please refer to the phone number listed on the back of the member's ID card.
F 312-281-1636
E SpecialtyRx@alliedbenefit.com

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. *(Required)*
- ☐ 3-6 months **recent** clinical information including medical history, physical exams and progress notes. *(Required)*
- ☐ The member's current signs/symptoms or chief complaints as well as the duration of the symptoms. *(Required)*
- ☐ Current medications as well as medications that have been TRIED/FAILED. *(Required)*
- ☐ Any **pertinent** lab work, including fecal occult blood test, culture reports, Hematocrit, Hemoglobin, Hormone studies and TSHs.
- ☐ Any **pertinen**t imaging reports, such as U/S, X-rays, CTs.

Today's Date:	**Date Medication Needed:**		
SECTION A - PATIENT INFORMATION			
Patient's First Name	**Patient's Last Name**		
Patient's DOB			
Employee's First Name	**Employee's Last Name**		
Employee's SS#	**Employee DOB**		
Address	**City**	**State**	**Zip**
Home Phone	**Work Phone**	**Cell Phone**	
SECTION B - INSURANCE INFORMATION			
Primary Insurance	**Pharmacy Benefit Manager**		
ID # / **Group #**	**Insured**	**Phone**	
Medicare? ☐ Yes ☐ No / **If yes, provide #**	**Medicaid?** ☐ Yes ☐ No / **If yes, provide #**		
Secondary Insurance	**Pharmacy Benefit Manager**		
Policy # / **Group #**	**Insured**	**Phone**	

SECTION C - PHYSICIAN INFORMATION

First Name				Last Name			
Address				**City**		**State**	**Zip**
Phone	**Fax**	**St Lic. #**		**NPI #**	**DEA #**		**UPIN**
Office Contact Name				**Phone**			

SECTION D - CURRENT MEDICAL INFORMATION ONLY

Primary Diagnosis	ICD-10 Code		Secondary Diagnosis		ICD-10 Code
Requested Medication Name	**Dose/Strength**	**Frequency**	**Directions**	**Quantity**	**# of Refills**
HCPCS/CPT Code	**Dose/Strength**	**Frequency**	**Directions**	**Quantity**	**# of Refills**
Tried and Failed Medications pertaining to request above.	**Dose/Strength**	**Frequency**	**Directions**	**Quantity**	**# of Refills**

SECTION E - BILLING AND SHIPPING INFORMATION

Is this Provider going to supply and bill for the medication?	☐ **Yes**	☐ **No**
If **YES**, is the Physician listed in section C the one billing for this medication?	☐ **Yes**	☐ **No**

If **NO**, please provide the name and phone number for the Physician or Facility supplying and billing for this medication.

Name: **Phone Number:**

Authorization Number (if required)

Administration Site:

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

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, your order may be delayed.

Shipping: ***(If shipping is required, please complete below.)***

☐ Physician's Office	☐ Home Care Agency (name and address if available)
☐ Patient's Home	☐ Ambulatory Infusion Center (location address)

Prescriber's Signature (required by law) Date