1199SEIU Benefit Funds

498 Seventh Avenue, New York, NY 10018-0009 • Tel: (646) 473-9200 • Fax: (646) 473-7469 • www.1199SEIUBenefits.org • @1199SEIUBenefits

BENEFITS ADMINISTRATION DEPARTMENT/PHARMACY SERVICES

PRESCRIPTION REQUEST FOR AUTHORIZATION

Fax completed form to (646) 473-7469.

MEMBER'S FULL NAME (FIRST, LAST) _____ MEMBER ID# _____

PATIENT'S FULL NAME (IF NOT MEMBER) _____ PATIENT'S DATE OF BIRTH (MM/DD/YYYY) _____ AGE _____

PRESCRIPTION:

DRUG NAME/DOSAGE/DURATION:

☐ **Brand-name Drug Requests:**
(brand-name drug with generic available) _____

☐ **Non-preferred Drug on the PDL**
(tier exception request) _____

☐ **Blood Clotting Agents** _____

☐ **Other** _____

For all other drug requests, please call Express Scripts at (800) 753-2851.

Initial Drug Therapy: ☐ Yes ☐ No **Renewal Treatment:** ☐ Yes ☐ No

ICD-10 Diagnosis Code(s) and Description:

PRINCIPAL _____

SECONDARY _____

MEMBER ID# PATIENT'S FULL NAME (FIRST, LAST)

Patient History:

Prior Treatment Medication Therapy and Outcomes:

Comments:

REQUEST SUBMITTED BY DATE (MM/DD/YYYY)

PHYSICIAN TIN/TAX ID#

PHONE FAX

X

PHYSICIAN SIGNATURE DATE (MM/DD/YYYY)

PHYSICIAN SPECIALTY

OFFICE ADDRESS CITY STATE ZIP

PHARMACY PROVIDING SERVICE PHARMACIST'S FULL NAME (FIRST, LAST)

PHARMACY ADDRESS CITY STATE ZIP

PHONE FAX

Please note: Any areas left blank will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST.

Complete this form and attach copies of pertinent medical documentation or copies of the physician's actual office chart to support your request. Fax completed form to (646) 473-7469.

The Fund's Pre-authorization Call Center is available Monday to Friday, 9:00 am to 5:00 pm, at (646) 473-7446.

Pre-Authorization requirements are regularly updated and are therefore subject to change; periodically visit our website at www.1199SEIUBenefits.org for our most recent pre-authorization requirements, authorization request forms and other pertinent information located in the "For Providers" section.