

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 not filled out 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.