Texas Standardized Prior Authorization Request Form for Prescription Drug Benefits

Section I — Submission

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| Submitted to: | Phone: | Fax: | Date: |

Section II — Review

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| [ ]  Expedited/Urgent Review Requested: By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient’s ability to regain maximum function.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Signature of Prescriber or Prescriber’s Designee |

Section III — Patient Information

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| --- | --- | --- | --- |
| Name: | Phone: | DOB: | [ ]  Male [ ]  Female  [ ]  Other [ ]  Unknown |
| Address: | City, State, ZIP code |
| Issuer Name (if different from Section I): | Member or Medicaid ID #: | Group #: |
| BIN # (if available) | PCN (if available) | Rx ID# (if available) |

Section IV — Prescriber Information

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| --- | --- | --- |
| Name: | NPI#: | Specialty: |
| Address: | City, State, ZIP code |
| Phone:  | Fax: | Office Contact Name: | Contact Phone: |

Section V — Prescription Drug Information

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| --- | --- | --- |
| Requested Drug Name | Strength | Route of Administration |
| Quantity | Days’ Supply | Expected Therapy Duration | **If this is a compound drug, identify all ingredients in Section VI, below.** |
| To the best of your knowledge this medication is:[ ]  New therapy [ ]  Continuation of therapy (approximate date therapy initiated: ) |
| For Provider Administered Drugs only, enter: HCPCS Code: NDC# Dose Per Administration |

Section VI — Prescription Compound Drug Information

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| Compound Drug Name  |
| Ingredients and NDC#s | Quantity of each ingredient |  Ingredients and NDC#s | Quantity of each ingredient |
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Section VII — Prescription Device Information

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| Requested Device Name | Expected Duration of Use |
| If applicable, enter HCPCS Code  |

Section VIII — Patient Clinical Information

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| Patient’s diagnosis related to this request: | ICD Version: | ICD Code: |
| Drugs patient has taken for this diagnosis: (Provide the following information to the best of your knowledge.) |
| Drug Name, Strength and Frequency | Dates Started and Stopped or Approximate Duration | Describe Response, Reason for Failure, or Allergy |
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| Drug allergies: | Height (if applicable): |
| Weight (if applicable): |

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| Attach or list below relevant laboratory values and dates: |
| Date | Test  | Value |
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Section IX — Justification (See Instruction Page Section IX)

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