EMPIRX HEALTH

PRIOR AUTHORIZATION INITIATION FORM

This form allows the pharmacy benefit manager to review the use of the medication for coverage. The submission of this form does not guarantee approval and coverage of the medication requested. Additional documentation will be required.

Confidentiality Notice: This document contains confidential protected health information and intended for the recipient below. If you are not the intended recipient, you are hereby notified that any disclosure, copying, and distribution of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the destruction of these documents.

Patient Information		**Prescriber Information**	
Patient Name:	Client ID:	Prescriber Name:	Specialty:
Patient DOB:	Request ID:	Phone:	Fax:
Patient ID:		NPI:	DEA:
		Office Address:	

Prescriber use only:				
Drug Name:	Strength:	Quantity:	Days Supply:	Expected Duration of Therapy:
Directions for use:				

Once complete, fax this form to 551-359-7177. For questions please call 877-361-4338 (select option 2).

This form is based on standard criteria and may not be applicable to all patients and plans and additional information or clarification will be required to evaluate requests. This form is intended for the purpose of obtaining new or continued prescription treatment for the above member.