Prior Authorization Request Form

PHONE: 1-888-589-3340
FAX: 1-602-585-0588

DisclosedRx
The Fully Disclosed PBM™

Must be filled in completely and correctly to avoid processing delays. Please allow 24-48 hours for review.

*** REQUIRED**

Patient Information

***Patient Name** _____ ***DOB (mm/dd/yyyy)** _____ ***Gender**_____

***Address** _____ ***City** _____ ***State** _____ ***Zip** _____

***Cardholder #** _____ ***Group #** _____ ***Relationship**_____

Height _____ **Weight** _____ ***Phone #** _____ ***Email** _____

Prescriber Information

***Prescriber Name** _____ **Specialty** _____ ***NPI**_____

***Address** _____ ***City** _____ ***State** _____ ***Zip** _____

***Office Contact** _____ ***Phone #** _____ ***Ext.** ____ ***Fax** _____

Medication Information

***Medication Name** _____ ***Strength** _____ ***Qty**____ ***D/S** _____

***Diagnosis** _____ ***New Therapy** ☐ Yes ☐ No **Length of Therapy** _____

***Date Needed**_____ **Delivery Location** _____ **# of Refills or NA** _____

*Medical History (Tried/Failed Therapies) ☐ N/A

In order to process this PA request you must attach office vist notes or lab results relating to the medication request.

Previous Medication	Strength	Sig	Start/End Date	Results
Previous Medication	Strength	Sig	Start/End Date	Results
Previous Medication	Strength	Sig	Start/End Date	Results
Previous Medication	Strength	Sig	Start/End Date	Results

Prescriber Signature _____

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