

1650 Spring Gate Lane Las Vegas, NV 89134 Tel: (877) 464-0079

Please Note: Medical Necessity Prior Authorization may be utilized to override both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

## **MARQUETTE GENERAL HOSPITAL (MGH) - UPHP**

## PRIOR AUTHORIZATION FORM COMPLETE AND FAX TO CATALYST Rx AT 888-852-1832

COMPLETE AND TAX TO CATALTST HX AT 000-032-1032							
MEMBER INFORMATION							
First Name				Last Name			
Plan							
Member ID				Date of Birth			
DRUG INFORMATION							
Drug Name							
Quantity				ICD-9			
Directions				Duration of TI	nerapy		
Diagnosis					-		
PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.							
Medication/Failure Reason:							
Has the patient been seen by any other provider for this condition?							
ESR:		CRP:	# Joints:	%BS <i>A</i>			
Sex:		leight: Weight:			BMI:		_
HA1C:		Hemoglobin: Hemate		atocrit:	crit: T-Score:		
Dialysis:		Long Term Care Facility:		Self Inj	Self Injecting:		
Stimulation test:		_/ Growth velocity:		#Ch	#Chemotherapy cycles/month:		
Mini-Mental Status Test: Baseline Free testosterone/Total testosterone:/							
HCV RNA viral load:		Viral Genotype:			ALT:		
PHYSICIAN INF	ORMATION	١					
Physician Signature				Date			
Physician Name				NPI#			
Phone Number				Fax Nu	Fax Number		
Action Needed		Only mark Urgent when standard review would seriously harm the member's life or health or ability to regain maximum functi		r ion <b>Pharma</b>	Pharmacy Fax		
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