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

MEMBER INFORMATION			
First Name		**Last Name**	
Plan			
Member ID		**Date of Birth**	

DRUG INFORMATION			
Drug Name			
Quantity		**ICD-9**	
Directions		**Duration of Therapy**	
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:**_____ **%BSA:**_____

Sex:_____ **Height:**_____ **Weight:**_____ **BMI:**_____

HA1C:_____ **Hemoglobin:**_____ **Hematocrit:**_____ **T-Score:**_____

Dialysis:_____ **Long Term Care Facility:**_____ **Self Injecting:**_____

Stimulation test:_____/_____ **Growth velocity:**_____ **#Chemotherapy cycles/month:**_____

Mini-Mental Status Test:_____ **Baseline Free testosterone/Total testosterone:**_____/_____

HCV RNA viral load:_____ **Viral Genotype:**_____ **ALT:**_____

PHYSICIAN INFORMATION			
Physician Signature		**Date**	
Physician Name		**NPI #**	
Phone Number		**Fax Number**	
Action Needed	Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function ☐ Urgent ☐ For Review	**Pharmacy Fax**	