**The Benefits of Better Health**

# Prior Authorization Request for Certain Medications

*Please note: If you need to submit a Brand vs. Generic Authorization Request or a Botox Authorization Request, please click on the appropriate link and submit that form instead of this one. Thank you.*

**Please complete this form and fax it to (816) 257-3235.** Date of request: ____________________

**Patient-Required Information**

*Patient name:__________________________/_____/ ______________________________________
First MI Last

*Patient address: ______________________________________________________________
Street

____________________________/_______________________/______________________
City State Zip

*Member ID: ____________________ *Patient date of birth:______/______/_______Sex: ❑ M ❑ F

**Physician-Required Information**

*Physician name:__________________________/_____/ ______________________________________
First MI Last

*Physician Tax ID number: ______________________________________________________
(Required information to process)

*Physician address: ____________________________________________________________
Street

____________________________/_______________________/______________________
City State Zip

*Phone: ______________________________ *Fax: ____________________________________

Your patient's benefit plan requires prior authorization for certain medications. You have prescribed a medication that requires a prior authorization for your patient. Your patient has requested a review to determine if the drug is consistent with plan rules for coverage.

*Drug name: ________________________ *Drug dosage: ______________________________

*Duration: ________________________ *ICD-CM code/s: ____________________________

- Copies of current patient clinical information including History and Physical exam and Treatment Plan from the past 3 to 6 months, as well as any pertinent tests completed with results.

**IMPORTANT**: All required information detail and documents must be included when faxing this completed authorization form. GEHA will notify you of our determination after reviewing the submitted information.

**Required information. Request cannot be processed without this information being included.*

**Questions: Call Customer Service at (800) 821-6136. Fax completed form to (816) 257-3235.**

***Payable benefits are subject to the terms and conditions of the Health Benefit Plan.***