Part B Drug Prior Authorization Request Form

Certain requests for coverage require review with the prescribing physician.

ADVANTAGE by Superior HealthPlan HMO SNP

PLEASE
- Complete this form and fax to the number listed under the logo.
- Note any information left blank or illegible may delay the review process.
- Use one form per medication prior authorization request.

Phone: 1-800-218-7508
Fax: 1-877-808-9368

I. MEMBER INFORMATION		II. PRESCRIBER INFORMATION	
Name:		Name:	
ID Number:		Specialty:	
Date of Birth:		NPI/DEA Number:	
Address:		Facility Name:	
City, State, Zip:		Address:	
Group Number:		City, State, Zip:	

III. MEDICATION REQUESTED	
Drug Name:	
Directions/SIG:	
Quantity:	
J-Code (if applicable):	

IV. ADDITIONAL CLINICAL INFORMATION	
ICD-9 Code:	
Diagnosis:	

Is the medication being requested for use in an ongoing investigational trial? ☐ Yes ☐ No

V. MEDICATION HISTORY (for this diagnosis

List therapeutic alternatives previously used with start/end dates and outcomes:

	Drug Name, Strength, and Dosage	Dates of Therapy	Reason for Discontinuation
1			
2			
3			

VI. PERTINENT CLINICAL INFORMATION

NOTE: Please attach any pertinent medical history or information for this patient that may support approval.

EXPEDITED REVIEW: By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize the member's health, life or ability to regain maximum function.

Prescriber Signature

_____ Date:_____

STANDARD REVIEW

Prescriber Signature

_____ Date:_____