



PRIOR AUTHORIZATION REQUEST FORM

For authorization, please answer each question and fax this form PLUS chart notes back to the MHC Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance 855-885-7695

Patient Information	Prescriber Information
Patient Name:	Prescriber Name and Specialty:
Member ID#:	NPI#:
Sex (circle): Male Female	Office Phone: () -
Date of Birth:	Office Fax: () -
Patient Phone: () -	Contact Person:

Diagnosis and Medical Information

Medication:	Strength and Route of Administration:	Frequency:
Height and Weight:	Expected Length of Therapy:	Quantity:
BMI:	Date Calculated: / /	Diagnosis Related to Medication:
Blood Pressure:	Taken on: / /	Drug Allergies:

Rationale for Prior Authorization

History of a medical condition, allergies or other pertinent information requiring the use of this medication:

Previous use of non-authorized and prior authorized medications tried and failed for this condition:

Name of Medication:	Reason for Failure:	Date of failure:
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Prescriber Signature:	Date:
-----------------------	-------

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.