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:

_____

_____

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

Name of Medication:	Reason for Failure:	Date of failure:
_____	_____	_____
_____	_____	_____

Prescriber Signature:	Date:

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Updated 05/20/2020