PharmaForce™ PBM

Medication Prior Authorization Form

Please complete this entire form and fax to 866-779-0781

Request Urgency

☐ Standard ☐ Urgent ☐ Pending Hospital Discharge

Member Information (Required)

Patient Name:	
Cardholder ID:	
Phone Number:	Date of Birth:
Plan Name:	

Prescriber Information (Required)

Prescriber Name:	
NPI #:	Prescriber Specialty:
Office Phone Number:	Office Fax Number:
Contract Person:	

Medication Information (Required)

Medication Name (include strength & dosage form): ☐ Check if Requesting **brand**	
Quantity:	Days Supply:
Directions for Use:	
Expected Length of Therapy:	
Diagnosis (please be specific as possible):	
ICD-10 Code:	
Continuation of Therapy: ☐ Yes ☐ No	
If YES: Has the member been on this medication in the last 180 days? ☐ Yes ☐ No	
Does the prescriber confirm the medication has been effective in treating the members diagnosis:☐ Yes ☐ No	

Please provide the medications the member has tried and failed, contraindication or intolerance to:

Medication Name: _____ Date: _____
Medication Name: _____ Date: _____
Medication Name: _____ Date: _____
Medication Name: _____ Date: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the prescriber feels is important to review?

By signing and submitting this prior authorization, the prescriber attests that the information provided is true and accurate to the best of their knowledge and understands that PharmaForce Group, LLC may perform a routine audit and request the medication information necessary to verify the accuracy of the information provided.

Prescribers Signature: _____ Date: _____

Please note: This request may be denied unless all required information is received within established timelines.