PRESBYTERIAN

Presbyterian Specialty Drug Prior Authorization Request Form

Please fax **COMPLETED** form to the Health
Plan's Pharmacy Services Department at: **1-505-923-5540** or **1-800-724-6953**
For help with this form, call (505) 923-5757 or toll-free 1-888-923-5757 (option3)

If this request is approved it is the prescriber's responsibility to provide a prescription to the Presbyterian Specialty Pharmacy: phone 505-823-8800 or 855-775-7737; fax 505-823-8833

If the request for a specialty mandated medication is denied and the patient wishes to self-pay, the prescriber should provide a prescription to the patient or any willing pharmacy.

PATIENT INFORMATION:

Patient Name (Last)	First:	Initial	DOB: (mm/dd/yyyy)
Patient Address:	City:	State	Zip
Daytime Phone:	Cell Phone:	E-mail Address:	Language:
Member ID Number:	Social Security Number:		Gender: **F** **M**
Persons(s) authorized to handle prescription info for patient. If minor, mother's maiden name and first name:			
Guarantee Name: (needed if patient is a child)	Patient's relationship to insurance subscriber: (wife, son, daughter, etc.)		

MEDICATION INFORMATION:

Drug:	Quantity:	J - CODE	NDC#:
Sig:			Refills:
ICD-9 Code:	Diagnosis:		

PRESCRIBER INFORMATION:

Physician Name (please print)	Signature:	Date:
Practitioner / Facility Address (include Suite, Building #, etc.)		Specialty:
Office Staff Contact Name (please print):	Phone Number (include ext):	Fax Number:

SHIPPING INFORMATION:

Date Needed:_____ SHIP TO: ☐ Physicians Office **OR** ☐ Member Home Address

INTERNAL INFORMATION:

Approved: ☐ PA Number:	Line of Service: ☐ASO ☐COMM ☐MCAID ☐PIC ☐SRCARE	Group Number
Indicate Approval dates: Start Date _____ thru _____	Co-Pay Information:	Pharmacist initial and Date:
☐ Bill Medical ☐ Bill PBM	Comments:	

SPECIALTY CARE PHARMACY INTERNAL USE ONLY:

340B Eligibility: Yes No	MRN#	Point of care:	340B Account: CDS Clovis Espanola Ruidoso Socorro Tucumcari

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