



# PRESBYTERIAN

## Presbyterian Specialty Drug Prior Authorization Request Form

Please fill out this form completely as it is also the prescription used by specialty pharmacy

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)

### 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: <b>F M</b>
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.)		

### PRESCRIPTION INFORMATION:

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

### PRESCRIBER INFORMATION:

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

### SHIPPING INFORMATION:

Date Needed: _____ SHIP TO: <input type="checkbox"/> Physicians Office <b>OR</b> <input type="checkbox"/> Member Home Address
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### INTERNAL INFORMATION:

Approved: <input type="checkbox"/> PA Number:	Line of Service: <input type="checkbox"/> ASO <input type="checkbox"/> COMM <input type="checkbox"/> MCAID <input type="checkbox"/> PIC <input type="checkbox"/> SRCARE	Group Number
Indicate Approval dates: Start Date _____ thru _____	Co-Pay Information:	Pharmacist initial and Date:
<input type="checkbox"/> Bill Medical <input type="checkbox"/> Bill PBM	Comments:	
<b>SPECIALTY CARE PHARMACY INTERNAL USE ONLY:</b>		
340B Eligibility: Yes No	MRN#	Point of care:
		340B Account: CDS Clovis Espanola Ruidoso Socorro Tucumcari

PRESBYTERIAN SPECIALTY CARE PHARMACY

Toll Free Phone: 1-855-775-7737

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