



General Prior Authorization Request Form

Pharmacy Department, 787-774-4832 (Fax)

Note: Any information left blank or illegible may delay the review process

Physician Information

Name: _____
License: _____ Physician specialty: _____
Address: _____
Telephone: _____ Fax: _____

Patient Information

General Information

Name: _____ Member ID: _____
Date of birth: _____ Address: _____
Sex: M F Weight: _____

Medication requested: (Include copy of prescription)

Name: _____ Dose: _____ Sig: _____

Medical Information

Please answer the following questions:

1) Diagnosis: _____ ICD-9 Code: _____

2) Please provide previous therapies (if applicable):

Drug: _____

Drug: _____

Drug: _____

Drug: _____

3) List outcomes from previous treatments:

Please provide any medical information which may support approval: (optional)

Physician signature: _____

Date: _____

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