Request for Prior Authorization- Medical Injectables

Prevea360 Health Plan is your partner in providing care.
In order to efficiently process your authorization request, the information below must be completed.

Member Information:

*Full Name: _____

Address: _____

Telephone #: (_____)_____ *DOB: ____/____/____

Primary Insurance Name (COB):_____

Primary Insurance ID and effective date #:_____

Member height _____

Member weight _____

Requested Diagnosis Code: _____

_____

Requested J, S or Q Code: _____

Drug Name and strength: _____

Directions _____

Requested Number of Units: _____ DOS From: _____/_____/_____ to _____/_____/_____

PLEASE SEND CLINICAL NOTES AND ALL SUPPORTING DOCUMENTATION

Requesting Provider:

Name: _____

NPI #: _____TIN#: _____

AHCCCS ID: _____

Telephone #: _____

Address: _____

Fax #: _____

Contact Name/Phone #:_____

Servicing Provider/Facility:

Name: _____

NPI #: _____TIN#:_____

AHCCCS ID: _____

Telephone #: _____

Address: _____

Fax #: _____

Contact Name/Phone #:_____

Submitted By: _____ (Please Print) Date: _____/____ /_____

(Please Print)

Please submit all supporting documentation and any applicable information with this request form

Pharmacy Department Phone: 608-828-6393
Pharmacy Department Fax: 608-252-0814