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:	**Servicing Provider/Facility:**
Name: _____	Name: _____
NPI #: _____TIN#: _____	NPI #: _____TIN#:_____
AHCCCS ID: _____	AHCCCS ID: _____
Telephone #: _____	Telephone #: _____
Address: _____	Address: _____
Fax #: _____	Fax #: _____
Contact Name/Phone #:_____	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 Fax: 608-252-0814