

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

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