

## **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 #: ()*DC	DB: <u>/ /</u>
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	
Paguasting Provider	
Requesting Provider:	Servicing Provider/Facility:
Name:	Servicing Provider/Facility:      Name:
Name: NPI #:TIN#:	Name: NPI #:TIN#:
Name:	Name:
Name:TIN#: NPI #:TIN#: AHCCCS ID: Telephone #:	Name:
Name:	Name: NPI #:TIN#: AHCCCS ID:
Name:	Name:
Name:	Name:

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

Pharmacy Department Fax: 608-252-0814

<sup>\*\*\*</sup>Confidentiality Notice\*\*\* This electronic message transmission contains information belonging to Prevea360 Health Plan that is solely for the recipient named above and which may be confidential or privileged. Prevea360 Health Plan EXPRESSLY PRESERVES AND ASSERTS ALL PRIVILEGES AND IMMUNITIES APPLICABLE TO THIS TRANSMISSION. If you are not the intended recipient, be aware that any disclosure, copying, distribution or use of this communication is STRICTLY PROHIBITED. If you have received this electronic transmission in error, please notify us by telephone at 608-828-6393. Thank you.