# PRESCRIPTION PRIOR AUTHORIZATION REQUEST FORM

**PLEASE FAX COMPLETED FORM TO 855-336-6612**

☐ **URGENT Review** ☐ **Standard Review**

In order to process your request as quickly as possible, all sections of the form must be completed legibly, and you must include relevant chart notes and/or labs as applicable. Our Medication Policies are available for your review at www.ventegra.com/medicationPolicies.aspx.

## Patient Information

| | | | | | |
|---|---|---|---|---|---|
| **Name** | | **Date of Birth** | | **Sex** | ☐ Male ☐ Female |
| **Plan Name** | | **Member ID** | | | |
| **Address** | | | **Phone** | | |
| **Medication Allergies** | | | | | |

## Prescriber Information

| | | | |
|---|---|---|---|
| **Prescriber Name** | | | |
| **Specialty** | | **NPI** | |
| **Phone** | | **Fax** | |
| **Form Completed by** | | | |

## Medication Information

| | | | | | |
|---|---|---|---|---|---|
| **Drug Name** | | **Strength** | | **Quantity** | |
| **Is the patient currently being treated with this medication?** | ☐ No ☐ Yes | If "Yes" for how long? | | | |
| **Diagnosis** | | | | | |

## Clinical Information

**Medication(s) previously tried and failed for this patient.**

| Drug Name and Dosage | Duration of Therapy (specify dates) | Response / Reason for Failure / Allergy |
|---|---|---|
| | | |

**Please list and attach supporting labs or other rest results:**

**Other information prescriber believes is important for review of this request:**

**Prescriber Signature:** **Date:**

By signature, the prescriber (or agent of the prescriber) confirms that all information provided is accurate.