DIRECT rx Solutions

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.

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.