

PRIOR AUTHORIZATION FORM GENERAL FORM

Incomplete forms may delay processing or result in an adverse determination. FOR URGENT REQUESTS, please call 800-710-9341.

FAX	BACK	то	318-21	4-4190

EXPEDITED REVIEW REQUESTED

PROVIDER INFORMATION		PATIENT INFORMATION				
Provider Name Provider NPI		Patient Name				
Office Contact Person		Southern Scripts ID	Rx Group Number			
Physician Address (Street, C	ity, State, Zip)	Patient DOB	Patient Phone			
Provider Specialty	Is fax secured? □ Yes □ No	Prescription #	Pharmacy			
Provider Phone #	Provider Fax #	Diagnosis Code	Date of Diagnosis			
CHECK ALL B	OXES THAT APPLY. IN	COMPLETE FORMS WILL	BE DENIED.			
Medication Name	Strength	Directions	Qty per month			
New Medication Ongoing Medication / Date Started Has the patient shown improvement while on therapy? Yes No						
1. Place of administration: Physician's Office, Clinic, Hospital, or Facility Patient Home						
2. Please indicate the condition being treated:						
3. Is this treatment acute or chronic?						
4. Severity of Disease: Mild Moderate Severe						
5. Anticipated Length of Therapy:						
 Does the patient have evidence of failure, intolerance or contraindication, or inadequate response to conventional therapies? Yes No 						
If yes, please provide detail (name of medications, doses, and dates of trials):						
7. Other pertinent information to support this medication is medically necessary (please attached additional information such as progress note if needed):						
I certify that, to the best of my knowledge, the information above is accurate.						
Prescriber's Signature Required	d:	Date:				
SOUTHERN SCRIPTS ONLY:						