

**MEMBERHEALTH  
INSURED DRUG PRIOR AUTHORIZATION REQUEST  
CONFIDENTIAL PATIENT INFORMATION**

**\*\* Illegible or Incomplete forms will be returned \*\***

**FAX TO:** MemberHealth Inc. 440-248-9644

**Call Center Phone #:** 888-868-5854

**URGENT REQUEST? (Check here)**

<b>Date of Request:</b>	<b>Patient Name: (Last, First, MI)</b>	<b>Member Rx ID number:</b>
<b>Sex: Male</b> <input type="checkbox"/> <b>Female</b> <input type="checkbox"/>	<b>Birth Date:</b>	<b>Phone:</b>
<b>Name of Prescription Group:</b>		

<b>PRINT Physician Name:</b>	<b>MD office Contact Person:</b>
<b>Physician DEA or State Lic #:</b>	<b>MD Phone:</b>
<b>Signature:</b>	<b>MD Fax:</b>

<b>Pharmacy Name:</b>	<b>Pharmacy Contact Person:</b>	
<b>NABP:</b>	<b>Pharmacy Phone:</b>	<b>Pharmacy Fax:</b>

**MEDICATION REQUEST**

<b>Drug Name &amp; Strength:</b>	<b>Qty:</b>	<b>Day Supply:</b>	<b>Date of Service:</b>
<b>NDC:</b>	<b>Refills:</b>	<b>Expected duration of therapy:</b>	
<input type="checkbox"/> <b>NEW Therapy</b> OR <input type="checkbox"/> <b>CONTINUING therapy</b> (Original Rx date: _____ )			

**MEDICAL JUSTIFICATION**

(All four areas in this section **MUST** be completed by member's healthcare provider or Pharmacist)

**Diagnosis (for requested drug and all relevant Dx):**

**Current Medication (s):**

**Prescriptions Tried and Failed:**

**MEDICAL JUSTIFICATION:**

**For MemberHealth Inc. Use Only**

- Approved     Denied     Deferred for Additional Information  
 Approved as Modified     PT not Eligible