Prior Authorization Request Form

AnthemPrescription

Please complete the following required information and fax to 1-800-601-4829

Or mail to: Anthem Prescription Management, LLC
8990 Duke Blvd.
Mason, Ohio 45040

We cannot process this prior authorization without the following information.

Physician Information

1. Physician Name: ______________________
2. Physician DEA#: ______________________
3. Physician Phone Number: ______________________
4. Physician Specialty (if applicable): ______________________
5. Physician Fax Number: ______________________
6. Physician Address: ______________________
7. Signature of Physician: ______________________
8. Date: ______________________

Patient Information

9. Policyholder or Insured Name: ______________________
10. Policyholder or Insured ID No. *(as shown on ID Card):* ______________________
11. Patient's Name: ______________________
12. Patient's Birthdate: ____/____/____ (MM DD YY)
13. Patient's Sex: ☐ M ☐ F

Medication Information

14. Which medication is requested? ______________________
15. What is the strength and dosage: ______________________
16. Quantity requested for 30 day supply: ______________________
17. Duration of therapy: ______________________
18. Form of medication to be prescribed: ☐ Tablet ☐ Injection ☐ Nasal Spray ☐ Other: ______________
19. If the patient requires more than the maximum allowable dosage, please provide explanation as to why: ______________________
20. What medication has this patient tried previously for this condition and the most recent date they were prescribed:

Medication	Date

Diagnosis and All Other Medical Conditions

21. What is the diagnosis for the medication requested? ______________________
22. Please reference any recent test results which has affected the physician's choice of therapy:

Test	Result	Reference Lab Range	Date

23. Medications this patient is currently taking and date originally prescribed:

Medication	Date

24. Any additional information for reason of request? ______________________
25. Contact person in office for request: ______________________
26. Contact Phone Number: ______________________

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