QualChoice® HEALTH INSURANCE

EXPRESS SCRIPTS®

Prior Authorization Form

# General Request Form

This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested. **Additional forms available: www.evernorth.com/prior-authorization-resources**

Fax completed form to **1-877-251-5896.**

If this is an **URGENT** request, please call 1-800-417-8164.

## Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

## Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI (required): _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address: _____

State: _____ Zip Code: _____

**Diagnosis:** _____ **ICD Code:** _____

**Please indicate which drug and strength is being requested:** _____

**Quantity requested:** _____ **for** _____ **days supply**

**Medications/Therapies tried and reason(s) for failure and/or any other information the physician feels is important to the review:**

_____

_____

_____

_____

_____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____ Phone Number: _____

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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