PHARMAVAIL
BENEFIT MANAGEMENT

Medication Prior Authorization Form

Member Group # ________________________________

Member ID # ___________________________________

Member Name __________________________________

Member Date of Birth ___________________________

Medication being requested: ____

Diagnosis/Medical Justification: ____

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Prescribing Physician: ____

Phone: _________________________________ Fax: _____________________________

Pharmacy Name____

Phone: _________________________________ Fax: _____________________________

Reason for Prior Authorization:

____Cost Exceeds Maximum Claim Amount ____Maintenance Medication

____ Plan Does Not Cover This Type of Medication ____ Duplicate Therapy

____ Approved ____ Denied ____ Need more information.

Effective_________________________ Thru ______________________________

Approved by: ____

Fax Completed Form to PharmAvail @ 678-236-0415 or call (800) 933-3734
Attach additional information or therapeutic justification deemed necessary.