Prior Authorization (PA) Request Form for Prescription Drugs

SHIELD PBM

FAX this completed form to Shield PBM at (888) 870 3823 or call (877) 659 6101.

I. Prescriber Information (print)	**II. Member Information** (print)
Prescriber Name & NPI:	Member name:
Office contact name:	Member ID #:
Fax:	Group #:
Phone:	Date of Birth:

III. Pharmacy Information (print)		
Pharmacy Name:	Phone:	Fax:

IV. Drug Information (one medication per request form)			
Drug name & strength:	Dosage form:	Dosing interval (sig):	Qty per Day:
Diagnosis relevant to this request:	Expected length of therapy:		

V. Medication history for this diagnosis

A. Is member currently treated with this medication?

☐ Yes For how long?_____ ☐ No

VI. Previous treatment and outcomes

Drug name & strength	**Dates of therapy**	**Reason for discontinuation**

VII. Clinical rationale for medication:

Prescriber/Agent Signature:	Date:

FOR INTERNAL USE ONLY

Rx#:	Cost:	Qty:	DS:	Misc:

☐ **Approved** ☐ **Denied** ☐ **No PA Necessary** ☐ **Need More Information**

Effective Dates:	Reviewed by:	Entered by:

Notes:

Appropriate clinical information (including lab reports, when appropriate) to support the request on the basis of medical necessity must be submitted. Appeal Information: If you believe that this decision adversely affects your patient's care, please contact our Customer Service line at (877) 659 6101 to request an Appeal form.