

Insulin Pen PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date:			
SECTION A - PATIENT INFORMATION			
First Name:		Last Name:	Member ID:
Address:			
City:		State:	Zip:
Phone:		DOB:	Allergies:
Primary Insurance:		Policy #:	Group #:
Is the requested medication NEW <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/> ? If so, start date: _____			
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No			
SECTION B - PHYSICIAN INFORMATION			
First Name:		Last Name: M.D./D.O.	
Address:		City:	State: Zip:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax Attention to:			
SECTION C - MEDICAL INFORMATION			
Medication:		Strength:	
Directions for use:			
Diagnosis (Please be specific for diabetes please include type I or type II):			ICD-10 CODE:
Explanation of why the Member is not able to use a preferred vial and syringe:			
Most recent HbA1c Levels and Dates:			
<u>HbA1c Level:</u>		<u>Date Drawn:</u>	

Physician Signature: _____ **Date:** _____

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