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MEDICARE PART D PRESCRIPTION DRUG AUTHORIZATION REQUEST FORM

☐ *STANDARD REQUEST* ☐ *EXPEDITED REQUEST*

This form is for authorization of prescription drug benefits only and must be COMPLETELY filled out.

GENERAL INFORMATION *Request Type (please check one)*

☐ Prior Authorization ☐ Step Therapy Exception ☐ Request Non-formulary Drug ☐ Request for Tiering Exception ☐ Appeal

Patient Name			Date of Birth (mm/dd/yyyy) M M D D Y Y Y Y
Patient's Home Address			Contract Number (include prefix)
City	State	Zip	

PHYSICIAN INFORMATION

Physician Name			Practice Type ☐ PCP ☐ Specialist
Practice Address			Physician UPIN
City	State	Zip	Provider Number
Office Phone	Office Fax		

TREATMENT INFORMATION

Drug Requested:	Dose Requested:
Reason for Use:	
ICD-9 Related to Use:	Duration of Disease:

List other medication this patient has tried with this condition:

Drug:__________ Regimen: __________ Dates of Therapy:______ to ______
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Drug:__________ Regimen: __________ Dates of Therapy:______ to ______
Drug:__________ Regimen: __________ Dates of Therapy:______ to ______

Does this patient have any co-morbid conditions that will affect therapy: ☐ Yes ☐ No
If so, please list: ____________________

I certify this information is correct. I understand that intentional misrepresentation of information herein may constitute fraud and be subject to legal action.

Recertification is required annually. ________________ Physician Signature ________ Date

SUBMISSION INSTRUCTIONS

FAX

You may fax the signed and completed form to Pharmacy Review at:
205 220-9575

MAIL

You may mail the signed and completed form to:

Part D Authorization Requests
Attention : Pharmacy Review
P.O. Box 12485 • Birmingham Alabama 35202-2485

PCSI-02 (09-2008)
H5884/H7917/S1030