

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**  
**4Rx Limit**

**Complete form in its entirety and fax to:  
 Prior Authorization of Benefits (PAB) Center at (866) 807- 6241**

**1. PATIENT INFORMATION**
**2. PHYSICIAN INFORMATION**

Patient Name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient Phone #: _____ Patient Email Address: _____	Prescribing Physician: _____ Physician Address: _____ Physician Phone #: _____ Physician Fax #: _____ Physician Specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician Email Address: _____
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**3. MEDICATION**
**4. STRENGTH**
**5. DIRECTIONS**
**6. QUANTITY PER 30 DAYS**

<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____
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**7. DIAGNOSIS: \_\_\_\_\_**
**8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**

**NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.**

<input type="checkbox"/>	<input type="checkbox"/>	Is the patient age 21 and over?
<input type="checkbox"/>	<input type="checkbox"/>	Is the patient receiving more than four (4) prescriptions within a given month?
<input type="checkbox"/>	<input type="checkbox"/>	Has the patient's monthly prescription limit been met?
<input type="checkbox"/>	<input type="checkbox"/>	Is the patient's prescription for an <i>essential</i> drug used in the adult's treatment plan for one of these conditions:
	<input type="checkbox"/>	acute sickle cell disease
	<input type="checkbox"/>	behavioral health disorder
	<input type="checkbox"/>	cancer
	<input type="checkbox"/>	cardiac disease (including hyperlipidemia)
	<input type="checkbox"/>	diabetes
	<input type="checkbox"/>	end stage lung disease
	<input type="checkbox"/>	end stage renal disease (ESRD)
	<input type="checkbox"/>	HIV/AIDS
	<input type="checkbox"/>	hypertension
	<input type="checkbox"/>	life-threatening illness (not otherwise specified)
	<input type="checkbox"/>	organ transplant
	<input type="checkbox"/>	terminal stage of an illness

**9. PHYSICIAN SIGNATURE**

_____ Prescriber or Authorized Signature	_____ Date
<small>Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.          Note: Payment is subject to member eligibility. Authorization does not guarantee payment.</small>	
<p><b>IMPORTANT WARNING:</b> This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is <b>STRICTLY PROHIBITED</b>. If you have received this message by error, please notify us immediately at <b>(800) 338-6180</b> and destroy the related message or return the document to us at 8407 Fallbrook Avenue AF13, West Hills, CA 91304. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.</p>	