MEDTIPSTER.COM, LLC.

REQUEST FOR PRIOR AUTHORIZATION

(ALL AUTHORIZATIONS ARE PENDING VALID ELIGIBILITY)

PRESCRIBING PHYSICIAN:

Name:_____
First **Last**

Direct Phone #: (_ _ _) - _ _ _ - _ _ _ _

Fax #: (_ _ _) - _ _ _ - _ _ _ _

Physician specialty: _____

BENEFICIARY:

Name:_____
First **Last**

Subscriber ID #: _____

Date of Birth: _ _ - _ _- _ _ _ _

Sex: ☐ **Female** ☐ **Male**

Name and title of person completing form (please print): _____

Drug name: **Strength:** **Administration Schedule:** **Length of Therapy:** **Quantity Requested:**

a) _____

b) _____

c) _____

Patient's diagnosis for use of this medication: _____

1. **Previous history of a medical condition, allergies or other pertinent medical information, that necessitates the use of this medication:**

   _____

2. **Has the patient been seen by any other provider for this condition?** ☐ **Yes** ☐ **No**

   If so, what was the prescriber's specialty? _____

3. **Previous non-prior authorized and prior authorized medications tried and failed for this condition:**

Name of medication	Reason for failure	Date:
_____	_____	_ _/_ _/_ _ _ _
_____	_____	_ _/_ _/_ _ _ _
_____	_____	_ _/_ _/_ _ _ _

4. **Pertinent laboratory test or procedure: (if applicable)**

Procedure:	Findings:	Date:
_____	_____	_ _/_ _/_ _ _ _
_____	_____	_ _/_ _/_ _ _ _
_____	_____	_ _/_ _/_ _ _ _

5. **Other Information:**

   _____

   _____

   _____

Submit Requests to:
Medtipster.com, LLC.
Email: priorauth@medtipster.com
Phone: (877) 207-5939 Fax: (248) 502-3167

MT PA COMMENTS:_____

_____

_____

_____

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_____

DT REC:_____TIME REC:_____
GCN: a)_____ b)_____c)_____
EC: a)_____b)_____c)_____
Qty:a)_____b)_____c)_____
Appd :a)_____b)_____c)_____
R.Ph:_____ DATE:_____
Entrd by: _____ DATE:_____
Auth # a)_____
b)_____
c)_____