PHOENIX PBM PRE AUTHORIZATION FORM

FAX TO: 888-835-3383

Phoenix Benefits Management manages the pharmacy benefit for your patient. Certain requests for coverage require review with the prescribing physician. **This document contains confidential information belonging to the sender that is legally privileged. This information is intended for the recipient only.**

Please answer the questions below and note that any information left blank or illegible could delay the review process.

Member NAME: ________________________ **Provider Name:** ________________

ID#: ___________________ **RX GRP#:** __________ **Provider NPI:**_________________

Provider Phone #: ____________________ **Provider FAX#:** _________________

MEDICATION requested: ____________________________ **DX:** ______________
DOSAGE, and DIRECTIONS:

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Is this a current medication? _________
If yes, how long has patient been taking?_____________________________

LIST ALL MEDICATIONS the patient has tried in the past to treat this condition. Some medications may be required prior to the approval of other medications.

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Please provide the following information:

Current Weight: _________ **Height:** __________ **BMI:** __________
Blood Pressure: _________ **Heart Rate:** _______ **Respiratory Rate:**_________

PHYSICIAN SIGNATURE: _____________________________ **Date:**_____________