

Please note: All information below is required to process this request. Monday – Friday: 8:00 AM to 4:30 PM Eastern  
 Phone: 1-866-287-6156 | Fax: 1-866-839-2372 | [www.carefirstchpdc.com](http://www.carefirstchpdc.com)

## Prior Authorization Request Form

Patient Information			Provider Information		
<b>Patient Name:</b>			<b>Provider Name:</b>		
<b>Member ID#:</b>			<b>NPI#:</b>	<b>Specialty:</b>	
<b>Date of Birth:</b>	<b>Phone:</b> ( )		<b>Office Phone:</b> ( )		
<b>Street Address:</b>			<b>Office Fax:</b> ( )		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>	<b>Office Street Address:</b>		
<b>Drug Allergies:</b>			<b>City:</b>	<b>State:</b>	<b>Zip:</b>
Requested Medication Information					
<b>Requested Medication Name:</b>			<b>Strength:</b>	<b>Dosage Form:</b> <i>(Capsules, Injection, etc.)</i>	
<b>Quantity Requested:</b>	<b>Frequency:</b>		<b>Route of Administration:</b> <i>(Oral, IV, SC, etc.)</i>	<b>Length of Therapy:</b> <i>(Please be specific)</i>	
<input type="checkbox"/> Check if requesting brand			<b>Pharmacy Name:</b>		
<input type="checkbox"/> Check if request is for continuation of therapy			<b>Phone:</b> ( )	<b>Fax:</b> ( )	
Clinical Information					
<b>What is the patient's diagnosis for the medication being requested?</b>			<b>ICD-10 Code(s):</b>		
<b>What medication(s) has the patient tried and/or failed?</b>					



This program is funded in part by the Government  
of the District of Columbia Department of Health Care Finance

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**Document any supporting labs or test results? (Please specify)**

NOTE: The most recent relative clinical notes and laboratory results must be included to ensure a complete PA review

**Other Pertinent History (Relative or pertaining to this request):**

**Request for Expedited (URGENT) Review:** By Checking this box, I certify that applying the standard timeframe may seriously jeopardize the health of the member or the member's ability to regain maximum function.

**Completed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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