Steward Health Care Network

HEALTH CHOICE GENERATIONS

Pharmacy Medication Prior Authorization / Exception Request Form

FAX: 1-877-424-5690

Phone: 1-800-656-8991

To ensure a timely response, please fill out the form completely and legibly.

☐ **Standard - Initial Coverage Determination (Up to 72 hours)/ Redetermination (Up to 7 days)**

☐ **Expedite - Initial Coverage Determination (Up to 24 hours)/ Redetermination (Up to 72 hours)**

Member Name (Last, First)	Member ID#	DOB	Date
Requesting Provider Name	NPI:	PCP (if different)	
Office Contact Person	Direct Phone #	Fax #	
Diagnosis 1 (include ICD-10)	Diagnosis 2	Diagnosis 3	

Please send all pertinent clinical documentation with this fax.

Name of Medication	Dosage	Quantity/ Amount	Duration
Sig/Instructions	Allergies		
List formulary medications tried / Include length of treatment and response with dates			
List formulary medications contraindicated / Reason			
☐ Hospital Discharge Date of Discharge:			

☐ This is a reauthorization of current medication. Recent clinical documentation is required. Please provide.

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Date Revised: December 2018