



# DC 37 HEALTH & SECURITY PLAN: PRIOR AUTHORIZATION REQUEST FORM

**DIRECTIONS:** Send this PA Form WITH Chart Notes, Letter of Medical Necessity & Supporting Documentation to:

Fax #: 212-815-1218      E-Mail: RXDRUG@dc37.net      If you have any questions, please call 212-815-1608

Patient/Member Information				Prescribing Physician/Midlevel Practitioner	
Name (Last, First):		Sex:		Name (Print):	
Date of Birth (MM/DD/YYYY):				Title: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA <input type="checkbox"/> PharmD	
SSN or OptumRx PID No.				NPI:	
Weight, Height and BMI:				Specialty:	
E-Mail:				E-Mail:	
Phone #:				Phone #:	Fax #:
Patient: <input type="checkbox"/> Participant <input type="checkbox"/> Spouse/Dom. Partner <input type="checkbox"/> Dependent				Mailing Address:	
Medication Information					
Rx Name	Dose	Route	Frequency	Duration Requested	Quantity/30 days
Diagnosis:				ICD Code:	
1. Has the patient been on this medication? If yes, please indicate dates and duration. If no, please skip to question 2.					
2. Is this a new medication? <i>If no, please skip to question 3.</i>					
3. If this is a new medication, please list the previous medications used for this condition below:					
Past Medication Name		Reason for Change/Failure		Dates and duration	
4. Attach Pertinent Laboratory Values or Findings from Procedures (if applicable)					
Procedure/Lab	Findings/Results	Dates			
Prescribing Physician/Midlevel Signature					Date

Please Note: Forms missing signature and date will not be accepted