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Medication Prior Authorization Form

<u>Instructions</u>: Please fill out completely and fax to 517.364.8413. Applicable chart notes <u>must</u> accompany request. Prior authorization criteria and the drug formulary are available at **PHPMichigan.com/Providers**. Our office and fax machine are open M-F 8 a.m. – 5 p.m., ET, except holidays.

Patient Information				Prescriber Information					
Today's date:				Provider name:					
Member name:				Provider NPI #:					
Subscriber Number:				Office phone:					
DOB:				Office fax:					
Patient's weight:					Office contact:				
Gender:		Office a	Office address:						
•									
Medication Information									
Medication:			Dose:			Frequency:			
Diagnosis & ICD Code:					If this is a continuation of therapy, how long has patient been on the medication?				
If medication is an infusion medication, please also complete the following:									
HCPCS code:	HCPCS code: This medication will be given: In office Hospital outpatient fa				Hospital/Facility name:				
				Facility NPI #:					
						Tax ID#			
Previous therapies a	ttempted:		Dose/fr	equency	Start	and stop date	es:	Reason for discontinuation	
Additional comments	here:								

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