southernscripts

Phone: 1-800-710-9341

PRIOR AUTHORIZATION FORM

GENERAL FORM

Incomplete forms may delay processing or result in an adverse determination. FOR URGENT REQUESTS, please call 800-710-9341.

FAX BACK TO 318-214-4190 ☐ **EXPEDITED REVIEW REQUESTED**

PROVIDER INFORMATION		PATIENT INFORMATION	
Provider Name	**Provider NPI**	**Patient Name**	
Office Contact Person		**Southern Scripts ID**	**Rx Group Number**
Physician Address (Street, City, State, Zip)		**Patient DOB**	**Patient Phone**
Provider Specialty	**Is fax secured?** ☐ **Yes** ☐ **No**	**Prescription #**	**Pharmacy**
Provider Phone #	**Provider Fax #**	**Diagnosis Code**	**Date of Diagnosis**

CHECK ALL BOXES THAT APPLY. INCOMPLETE FORMS WILL BE DENIED.

Medication Name	Strength	Directions	Qty per month

☐ **New Medication** ☐ **Ongoing Medication / Date Started** _____

Has the patient shown improvement while on therapy? ☐ **Yes** ☐ **No**

1. Place of administration: ☐ Physician's Office, Clinic, Hospital, or Facility ☐ Patient Home
2. Please indicate the condition being treated:
3. Is this treatment acute or chronic?
4. Severity of Disease: ☐ Mild ☐ Moderate ☐ Severe
5. Anticipated Length of Therapy:
6. Does the patient have evidence of failure, intolerance or contraindication, or inadequate response to conventional therapies? ☐ Yes ☐ No

   If yes, please provide detail (name of medications, doses, and dates of trials):
7. Other pertinent information to support this medication is medically necessary (please attached additional information such as progress note if needed):

I certify that, to the best of my knowledge, the information above is accurate.

Prescriber's Signature Required:_____Date:_____

SOUTHERN SCRIPTS ONLY:

Please Return Completed Form To: Fax number: (318) 214-4190