DC 37 HEALTH & SECURITY PLAN: PRIOR AUTHORIZATION REQUEST FORM

Please send this PA Form along with Chart Notes, Letter of Medical Necessity & Supporting Documentation to:
Fax #: 212-815-1218 E-Mail: Drug_Unit@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:** ☐ MD ☐ DO ☐ NP ☐ PA ☐ PharmD
SSN or OptumRx PID No.		**NPI:**
Weight, Height and BMI:		**Specialty:**
E-Mail:		**E-Mail:**
Phone #:		**Phone #:** **Fax #:**
Patient: ☐Participant ☐ Spouse/Dom. Partner ☐ 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? *If no, please skip to question 3.*

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