



417 20<sup>th</sup> Street North, Suite 1100  
**Health Services Department**  
 Birmingham, AL 35203  
 Phone Number: (205) 933-1201 Option 1  
 Fax Number: (205) 449-7049

**Medical Benefit Drug Prior Authorization Form**

Please fax completed form with **CLINICAL NOTES**

Patient Information:		Prescriber Information:	
Patient Name:		Prescriber:	NPI #:
Member ID #:		Office Phone #:	Fax #:
Date of Birth:		Facility where drug will be administered:	
Phone #:		Facility Tax ID #	
Address:		Office Contact Name and Telephone #	

**Request Type:**

Initial Authorization                       Authorization Renewal                       Urgent/Expedited



**If your request is urgent, please call prior to submitting your request.**

Phone: 205-933-1201 opt 1 or 800-294-7780

**Medication and Diagnosis Information:***(Please include NDC for Unclassified Codes)*

WT:

HT:

Diagnosis:	ICD 10:	Drug Name:	HCSPS:	Route:	Frequency:	Quantity:

Alternate Drug(s) Previously Tried or Contraindicated:

Drug: \_\_\_\_\_ Date(s) Used: \_\_\_\_\_ Outcome: \_\_\_\_\_

Drug: \_\_\_\_\_ Date(s) Used: \_\_\_\_\_ Outcome: \_\_\_\_\_

Drug: \_\_\_\_\_ Date(s) Used: \_\_\_\_\_ Outcome: \_\_\_\_\_

 Indicate if request is drug to drug supply shortage

If Injectable or Nebulized: Where is it being administered? Must check one

 Home (Self-Administered) Long-Term Care Skilled Nursing Facility Provider's Stock (Buy & Bill) Provider's Office (Patient Provides)**Rational for Request: (Please attached relevant and clinic notes)**\_\_\_\_\_  
Physician's Signature\_\_\_\_\_  
Date