

MEDICATION PRIOR AUTHORIZATION REQUEST FORM

Use this form to obtain authorization for:

P+4044-1108

1. Medications requiring prior authorization – identified as “(PA)**” in the formulary.
2. Non-formulary medications for two-tier members (a 50% coinsurance automatically applies for three-tier members, and prior authorization is unnecessary).

Form directions:

1. **Review the formulary first to ensure suitable alternatives were attempted.**
2. Complete the form entirely so a proper review can be performed.
3. Submit this form via fax or mail using contact information below.

Prescriber Information

Prescriber Name (print):	Prescriber Phone Number:
Prescriber Signature:	Prescriber Fax Number:

Member Information (a patient clinic sticker may be affixed to this area of the form)

Member Name:	Date of Birth:
Physicians Plus Member Number:	

Medication Information

Medication Name:	Strength:	Schedule:	Duration of Therapy:

Clinical Justification

Diagnosis:	
Justification: - State any formulary alternatives that have failed - Attach additional information to assist us in reviewing the request	<hr/> <hr/> <hr/> <hr/>

You and your patient will be notified of our decision in writing.

Mailing Address:
Physicians Plus Insurance Corporation
Attn: Pharmacy Services
P.O. Box 2078
Madison, WI 53701-2078

Physicians Plus Pharmacy Services Fax:
(608) 327-0324

Prior Authorization Questions?
(608) 260-7803 or (800) 545-5015