DisclosedRx
The Fiduciary and Fully Disclosed PBM®

PO Box 701
Washington, IN 47501
Phone: 480-561-6005
Fax: 602-585-0588

Prior Authorization Request Form
General

☐ Standard ☐ Urgent ☐ Reconsideration/Appeal

Patient Information

Patient Name: ______________________ DOB (mm/dd/yyyy): ______________ Gender: ________
Address: ______________________ City: ______________________ State & Zip: ____________
Cardholder ID: ______________________ Group #: ______________________ Relationship Code: ________
Phone Number: ______________________ Email address: ______________________________

Prescriber Information

Prescriber Name: ______________________ Specialty: ______________________ NPI: ______________
Address: ______________________ City: ______________________ State & Zip: ____________
Office Contact: ______________________ Phone Number: ______________________ Fax Number: ____________

Medication Information

Drug Name: ______________________________ Strength: ______________ Quantity: ______________
Directions: ____ Day Supply: ____________
Indicate Request Type: ☐ New Start ☐ Renewal Therapy Start Date (if applicable): ______________________
Diagnosis: ______________________ ICD 10 Code: ______________________

Prior Authorization Request Information

Supporting documentation (i.e., chart notes, labs, etc.) must be attached to avoid processing delays

For all requests:

1. Does the patient have any FDA contraindications to the requested agent? ☐ Yes ☐ No
2. Will the patient be taking any other medications in combination with the requested agent for the treatment of this diagnosis? If yes, please list: ______________________________ ☐ Yes ☐ No
3. Has the patient had an inadequate clinical response of at least 12 weeks, intolerance, or contraindication to any medications used to treat this diagnosis? If yes, please list below. ☐ Yes ☐ No

Drug Name/Strength:	Start Date:	End Date:	Outcome:

Please continue to the next page.

© 2024 All Rights Reserved. Revision Date: 12/2024

Patient Name:	DOB:

For Renewal Requests:

1. **Has the patient had a positive clinical response to therapy? Must submit objective documentation.** ☐ **Yes** ☐ **No**
2. **Does the patient have any FDA contraindications to the requested agent?** ☐ **Yes** ☐ **No**

Prescriber Signature: ________________________________ **Date**: ______________________

Authorized Agent's Name: ____________________________

Please fax this request to 602-585-0588 or our secure email at care@disclosedrx.com
Mail Requests to: DisclosedRx Clinical Team
PO Box 701 Washington, IN 47501

Additional Comments/Notes:

© 2024 All Rights Reserved. Revision Date: 12/2024