



Health Plan Arizona

# Specialty Prescription Prior Authorization Form

## Fax (888) 773-7386

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information. Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>. If you have any questions please call (866) 848-9870.

Last Name	First Name	Today's Date	Date Needed
Home Phone Number	Work Phone Number	Prescriber	Office Contact
Home Address	City	State	ZIP
Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home		Phone Number	Fax Number
SCAN ID number	Date of Birth	Special Instructions (i.e. Non-English Speaking Patient, etc.)	

**Complete Prescription Information before Faxing**

Medication: \_\_\_\_\_

Sig: \_\_\_\_\_

Qty: \_\_\_\_\_ Dose(s)

Refills x \_\_\_\_\_ month(s)

**Statement of Medical Necessity**

Primary Diagnosis: \_\_\_\_\_

ICD 9 Code: \_\_\_\_\_

Medical History: \_\_\_\_\_

Estimated Start of Therapy: \_\_\_\_\_

Primary Insurance Company	Phone	Name of Insured	ID Number	Group Number
Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number

Please provide comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?

Physician's Signature: \_\_\_\_\_ UPIN/DEA #: \_\_\_\_\_ State License #: \_\_\_\_\_

**PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS**