



Express Scripts, Inc.
Prior Authorization Request Form
Fax (877) 837-5922

Phone (800) 417-8164

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information. Our standard response time for prescription drug coverage requests is 2 business days. View our formulary online at http://www.scanhealthplan.com.

Please Note: If the following information is NOT filled in completely, correctly or legibly, the authorization review will be delayed.

Insurance Company SCAN

Patients ID#

Patient Full Name

Patient Date of Birth

Medication Requested

Quantity Requested for days supply

Physician Name (please print clearly)

Physician DEA number (required)

Physician Address

Physician Phone

Physician Fax

Diagnosis-Indication-Medical History (reason for use of this medication)

[Blank lines for medical history]

Other Medications/Therapies Tried and Reason(s) for Failure

[Blank lines for other medications]

Physician Signature Date

Office Contact Person

Any further information pertaining to this drug request should be included and attached to this form.