



Specialty 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
VH ID number	Date of Birth	Special Instructions (i.e. Non-English Speaking Patient, etc.)	

<p>Complete Prescription Information Before Faxing</p> <p>Medication: _____</p> <p>Sig: _____</p> <p>Qty: _____ Dose(s)</p> <p>Refills x _____ month(s)</p>	<p>Statement of Medical Necessity</p> <p>Primary Diagnosis: _____</p> <p>ICD 9 Code: _____</p> <p>Medical History: _____</p> <p>Estimated Start of Therapy: _____</p>
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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