2181 E. Aurora Road, Suite 201
Twinsburg, OH 44087
Customer Services Phone: 1-800-361-4542

PRIOR AUTHORIZATION FORM

In order to complete the review process, please provide the following documentation:

- **Chart notes documenting medications tried, failed, or contraindicated: Attach documentation**
- **Clinical rationale for treatment: Attach documentation**
- **Pertinent laboratory tests and results: Attach copies of results**

COMPLETE AND FAX TO ELIXIR AT 1-866-422-9119

Patient Information		**Prescriber Information**	
Contact Person:		Date Faxed:	
Patient Name:		Prescriber Name and Specialty:	
Date of Birth:		NPI:	
Member ID:		Office Phone:	
Group Number:		Office Fax:	
Requested Medication and Diagnosis			
Medication:	Strength:	Frequency:	Quantity:
Diagnosis:		Expected Length of Therapy:	

Medical History and Rationale for Prior Authorization Request

Clinical Rationale for Prior Authorization Request: (e.g. history of present utilization, past medical history, etc.)

_____

_____

List all medications tried and failed, including dose, duration, and outcome of each therapy:

Medication:	Date:	Reason for failure: