Customer Services Phone: 1-800-361-4542

Specialty Drug Prior Authorization Request Form

COMPLETE AND FAX TO ELIXIR SPECIALTY 1-877-309-0687

PHYSICIAN INFORMATION			
Contact Person		**Date Faxed**	
Physician Name		**Physician Specialty**	
Phone Number		**Fax Number**	
NPI or DEA #		**Pharmacy Fax**	

MEMBER INFORMATION			
First Name		**Last Name**	
Plan	**TOTAL HEALTH CARE**		
Member ID		**Date of Birth**	

Drug requested and directions for use (e.g. mg/day):	Diagnosis:

Is patient currently taking drug (yes, no)? _____ If yes, for how long? _____

Other drugs previously tried:

Name of drug, dose and date	**Outcome (**reason why it failed or was not tolerated)
_____	_____
_____	_____
_____	_____

Other reason(s) why this particular drug was selected *(attach chart notes, pertinent laboratory tests or procedures and results, letter or supporting literature as appropriate)*

DRUG/CLINICAL INFORMATION

☐ Initial request ☐ Renewal Drug requested: _____ Number of refills: _____

Strength/Quantity: _____ Daily dose: _____ Height: _____ Weight: _____

Sig. _____

☐ Supplies package (no charge): sharps disposal unit (regular or large), alcohol wipes (100 per box), and syringes as necessary

Prescriber's Name _____ Date _____

Print Name

Signature _____ _____