Texas Standard Prior Authorization Request Form for Prescription Drug Benefits

Section I – Submission

Submitted to:	Phone:	Fax:	Date:

Section II – Review

☐ **Expedited/Urgent Review Requested:** By checking this box and signing and dating below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Signature of Prescriber or Prescriber's Designee:_____ Date:_____

Section III – Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown
Address:	City:	State:	ZIP Code:
Issuer Name (if different from Section I):	Member or Medicaid ID #:	Group #:	

Section IV – Prescriber Information

Name:		NPI #:	Specialty:	
Address:		City:	State:	ZIP Code:
Phone:	Fax:	Office Contact Name:	Contact Phone:	

Section V – Prescription Drug Information

(If this is a compound drug, identify all ingredients in Section VI, below.)

Requested Drug Name:				
Strength:	Route of Administration:	Quantity:	Days' Supply:	Expected Therapy Duration:

To the best of your knowledge this medication is:

☐ New therapy ☐ Continuation of therapy (approximate date therapy initiated: _____

For continuation of therapy, complete the following to the best of your knowledge:

☐ Patient is adhering to the drug therapy regimen.

☐ The drug therapy regimen is effective.

Note: For a request for prior authorization of continuation of therapy (other than a request for a step-therapy exception as provided in 28 TAC Section 19.1820(a)(13)(B)), it is not necessary to complete Sections VIII or IX unless there has been a material change in the information previously provided. Section IX must be completed for a request for a step-therapy exception.

For Provider Administered Drugs Only:

HCPCS Code:_____ NDC #:_____ Dose Per Administration:_____

Section VI – Prescription Compound Drug Information

Compound Drug Name:					
Ingredient	NDC #	Quantity	Ingredient	NDC #	Quantity

Section VII – Prescription Device Information

Requested Device Name:	Expected Duration of Use:	HCPCS Code (If applicable):

Section VIII – Patient Clinical Information

Patient's diagnosis related to this request:	ICD Version:	ICD Code:

(Provide the following information to the best of your knowledge)

Drugs patient has taken for this diagnosis:

Drug Name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason for Failure, or Allergy

Drug Allergies:	Height (if applicable):	Weight (if applicable):

Relevant laboratory values and dates (attach or list below):

Date	Test	Value

Section IX – Justification (See the "Additional Information and Instructions" section)
