



SCOTT & WHITE HEALTH PLAN

Texas Friendly

Fax completed form to (254) 774-1623
Scott and White Prescription Services
Division of Scott and White Health Plan
Phone: (800) 728-7947

Request Form for Medications Requiring Prior Authorization

Patient Information	
Patient name: _____	Date of Request: _____
Patient date of birth: _____	Patient SW MRN (if applicable): _____

Scott and White Health Plan formularies can be found at www.swhp.org –Provider tab/Pharmacy Services

Medication/Medical Information
Prior authorization request for (name of drug): _____
Dose and frequency: _____
Diagnosis with ICD-9 code: _____
For injectable drugs, indicate location of administration (circle one): Home -or- Physician office/clinic
Duration of treatment (circle one): One time only / Other, please specify _____
Indicate medications tried, reason for failure, side effects, why formulary agent is not medically appropriate: _____

Incomplete forms will delay processing time and drug therapy

Provider Information
Provider printed name: _____ NPI: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (____)-____-____ Fax: (____)-____-____
Name of supervising physician for requesting PA or NP (if applicable): _____
Provider signature: _____

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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