



Request Form for Medications Requiring Prior Authorization

Fax completed form to (254) 298-6186

Scott & White Prescription Services
Division of Scott & White Health Plan
Phone: (800) 728-7947

Date of Request: _____

Member Name: _____

For HP Use Only:

Member #

DOB: _____ **MRN:** _____ **Diagnosis:** _____

Physician Requesting: *(please print name)* _____

Prior Authorization Request for (name of drug): _____

Drug dose and frequency: _____

For injectable drugs, indicate location of administration (Circle One): **Home** **Physician office/Clinic**

Indicate below why formulary agent is not medically appropriate, medications tried, results, side effects.
(Note: requests for non-formulary medications will be covered at the non-formulary copay regardless of medical appropriateness or necessity, per the patient's contract.)

Description of how this request benefits Health Plan membership:

Duration of treatment (Circle One): **One time only** **Other, please specify** _____

Practitioner Signature: _____ **Practitioner Number:** _____

Clinic: _____

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

Incomplete forms will delay processing time and drug therapy