Quality Care Partners
434 Main St
Zanesville, OH 43701

RX PRIOR AUTHORIZATION REQUEST FORM

Drug Name: _____

Patient Information

PATIENT NAME (LAST, FIRST, MI)			MEMBER ID
DOB	AGE	SEX	

Physician Information

PRESCRIBER'S NAME	CONTACT PERSON	NPI: TAX ID:
ADDRESS	PHONE	FAX

Medication Request

DIAGNOSIS / INDICATION - *For off-label indications, please supply authoritative medical literature to support this request*			ICD-10 CODE
DRUG NAME & STRENGTH REQUESTED	SIG		REFILLS
ADMINISTRATION COST	MEDICATION COST		
DURATION OF THERAPY	NEW THERAPY ☐ YES ☐ NO	DATE OF LAST EVALUATION (INCLUDE OFFICE NOTE)	NEXT APPOINTMENT-DATE

Place of Service

PLACE OF SERVICE NAME		NPI: TAX ID:
ADDRESS	PHONE	FAX

Place of Service for Administration:

- ☐ Physician's Office
- ☐ Infusion Center
- ☐ Home Self-Injection
- ☐ Outpatient Facility
- ☐ Pharmacy
- ☐ Home Infusion
- ☐ Other _____

Information needed:

- ☐ Office Note
- ☐ Recent Imaging
- ☐ Current Symptoms
- ☐ Medications tried/failed
- ☐ Current labs

Notes: _____