P.O. Box 327, MS 432
Seattle, WA 98111-0327

PREMERA HMO

Pharmacy Services Prior Authorization Request Form

Please allow 24 to 48 hours after we receive all the information for a response.
For Medical Policy information please visit our website at: **www.premera.com**

Please fax this back to Pharmacy Services

Fax Number	**Phone Number**
1-888-260-9836	**1-888-261-1756**

Patient Name:		ID Number:	
Date of Birth:		ICD code:	
Prescriber's Name:		☐ MD ☐ DO ☐ ARNP ☐ PA-C	
Fax Number:			
Prescriber's Address:			
Prescriber's Signature	*Date*	*Phone Number*	*Ext.*

Requested medication, CPT code, strength and dosing schedule

Diagnosis related to use:

Medications Tried

	Medication name	Strength	Dosing schedule	Therapy duration	Dates tried	Reason therapy stopped
1						
2						
3						
4						
5						

Additional pertinent information

**** Please submit this fax-back sheet along with *relevant* chart notes to Pharmacy Services ****

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information

Internal Use Only	Approved Time Period: ☐ _____ Months
☐ Approve/Fax	Start Date _____ End Date _____
☐ Deny	Date Approved _____ By _____

Unless specifically requested elsewhere in this document, please do **not** send a DNA or other genetic sample, or the results of any genetic typing, test or analysis, including DNA.