rightway

Rightway
Phone: 888.665.1885
Fax: 888.498.1038

GENERAL AUTHORIZATION FORM
Prior Authorization, Step Therapy & Quantity Limit Exception

☐ Standard Request ☐ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	☐ Male ☐ Female	NPI#:	Specialty:
Pharmacy Benefits ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Frequency:
Quantity Dispensed:	Day Supply:	☐ Generic ☐ Brand Necessary

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

☐ New medication ☐ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Billing Information

☐ Billed by PHARMACY delivered to the member or provider for administration.	☐ Billed under MEDICAL benefit. J CODE:______________ ICD-10 Code:______________	Place of Administration: ☐ Physician's Office ☐ Hospital/Clinic ☐ Patient Home

Clinical Information

Diagnosis:	Date Diagnosed:

History of Medications Used to Treat Above Condition

☐ No other medications have been used to treat this condition

Medication	Strength	Frequency	Dates of Therapy		Reason for Discontinuing
			Start	End	

Please provide any additional information which should be considered in the space below:

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Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: ______________________________

Date: ______________________________

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