curative

Curative Rx Prior Authorization Form
PHONE: 855-414-1083
FAX: 888-293-4075
pharmacypa@curative.com

Please be sure to:

1. Complete all fields and sign form.
2. **Attach clinical chart notes. *Failure to do so could result in delayed processing.**
3. Send signed and completed form to the contact information listed above.

Provider's Office:	Today's Date:
Phone:	Fax:

☐ **Expedited/Urgent Review Requested:** By checking this box and writing my name below, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Name of Prescriber or Prescriber's Designee:	**Date:**

Patient Information

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ Unknown
Issuer Name *(if different from Provider's Office)*:		Member or Medicaid ID #:	

Prescriber Information

Name:		NPI #:	Specialty:	
Address:		City:	State:	Zip:
Phone:	Fax:	Office Contact Name:	Contact Phone:	

Prescription Drug Information

Requested Drug Name:				
Strength:	Route of Administration:	Quantity:	Days' Supply:	Expected Therapy Duration:

To the best of your knowledge this medication is:

☐ New therapy ☐ Continuation of therapy *(approximate date therapy initiated)*: _____

For continuation of therapy, complete the following to the best of your knowledge:

☐ Patient is adhering to the drug therapy regimen. ☐ The drug therapy regimen is effective.

Note: For a request for prior authorization of continuation of therapy (other than a request for a step-therapy exception as provided in 28 TAC Section 19.1820(a)(13)(B)), it is not necessary to complete Sections VIII or IX unless there has been a material change in the information previously provided. Section IX must be completed for a request for a step-therapy exception.

For Provider Administered Drugs Only:

HCPCS Code:	NDC #:	Dose Per Administration:

Prescription Device Information

Requested Device Name:	Expected Duration of Use:	HCPCS Code *(if applicable)*:

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Patient Clinical Information

Patient's diagnosis related to this request:	ICD Version:	ICD Code:

(Provide the following information to the best of your knowledge)
Drugs patient has taken for this diagnosis:

Drug Name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason for Failure, or Allergy

Drug Allergies:	Height *(if applicable)*:	Weight *(if applicable)*:

Relevant laboratory values and dates (attach or list below):

Date	Test	Value

Justification

- Provide pertinent clinical information to justify requests for initial or ongoing therapy, or increases in current dosage, strength, or frequency.
- Explain any comorbid conditions and contraindications for formulary drugs.
- Provide details regarding titration regimen or oncology staging, if applicable.

Reminder: Please attach clinical chart notes. Failure to do so could result in delayed processing.