



## Prior Authorization Drug Request

**IMPORTANT INFORMATION REQUIRED -**  
**FORM CANNOT BE PROCESSED WITHOUT REQUIRED DOCUMENTATION.**

A separate request must be completed for each drug for each patient.

Date: \_\_\_\_\_ Office Nurse/Manager: \_\_\_\_\_

Prescriber: \_\_\_\_\_ Office Phone#: \_\_\_\_\_

Client: \_\_\_\_\_ Office Fax#: \_\_\_\_\_

Group: \_\_\_\_\_

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Member #: \_\_\_\_\_ Drug Name: \_\_\_\_\_

**MaxorPlus Comments:** The above patient has a prescription for a medication which requires a prior authorization. This drug will be prior authorized if all the criteria have been met. Please indicate the diagnosis, other treatments tried and any information relevant to the review of this request below and fax the form back to us as instructed.

Dosage: \_\_\_\_\_ Directions for use: \_\_\_\_\_

Quantity: \_\_\_\_\_ Anticipated duration of therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

ICD-9 Code(s): \_\_\_\_\_

Indication: \_\_\_\_\_

Prior alternative treatment(s) provided for this condition: \_\_\_\_\_

**Required Supporting Clinical Statement** (such as protocols or evidence based guidelines followed, concurrent therapies, comorbidities, outcomes of previous drugs and therapies used, etc.):

Relevant Lab Values: \_\_\_\_\_

Prescriber Signature / Date: \_\_\_\_\_

Fax toll free to **844-370-6203** or mail to: MaxorPlus, 320 S. Polk, Suite 200, Amarillo, TX 79101  
You will be notified within 24-48 hrs whether the request was approved. For inquiries, call 800-687-0707.