Medication Prior Authorization Request

NEXTLEVEL HEALTH

Phone: 866-399-0928 Fax: 866-399-0929

Instructions:

1. Fill out all fields.
2. Fax completed form to the number above.
3. Please write legibly.
4. Only 1 medication per form.

Date of Request:	

Patient Information	**Prescriber Information**
Patient Name:	Prescriber Name and Specialty:
Member ID #:	NPI #:
Sex: ☐ Male ☐ Female	Office Phone:
Date of Birth:	Office Fax:
Patient Phone:	Contact Person:

Diagnosis and Medical Information		
Medication:	Strength & Route of Administration:	Frequency:
Height & Weight:	Expected Length of Therapy:	Quantity:

Diagnosis Related to Medication Request:			
Drug Allergies:			
Has the member taken this medication before?		If yes, what dose/strength? For how long?	

Rationale for Prior Authorization
History of a medical condition, allergies or other pertinent information requiring the use of this medication:

Previous medications tried and failed for this condition		
Name/Strength of Medication	Reason for Failure	Date(s) of Failure

Include the pertinent laboratory results to ensure a complete PA review.	
Prescriber's Signature:	Date: