# Request for Prior Authorization Form

Smi+hRx

**Submit requests to:**

**SmithRx**
PO Box 514
150 Sutter St.
San Francisco, CA 94104

**Questions? Contact us:**

**Phone:** 1.844.512.3030
**Fax:** 1.866.642.5620

**Please submit one drug per PA form**

☐ **Expedited/Urgent**

By checking this box, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member **OR** the member's ability to regain maximum function

## Prescribing Physician

**Prescriber Name**

**Physician Specialty**

**NPI Number**

**DEA Number**

**Phone Number**

**Fax Number**

**Requestor Name**

**Office Contact Name**

## Patient Information

**Last Name**

**First Name**

**M.I.**

**ID Number**

**Date of Birth** (MM/DD/YYYY)

**Sex**

☐ M ☐ F

**Allergies**

**Height** (in/cm)

**Weight** (lb/kg)

## Requested Drug Details

**Drug Name**

**Strength**

**Dosage Form**

**Admin. Schedule**

**Length or Therapy / # of Refills**

**Quantity**

**Requesting a Brand Drug?**

☐ Yes ☐ No

**Directions for use:**

## Patient History

**Patient's diagnosis for use of this medication**

**ICD 9/10**

**Please provide a supporting statement or clinical rationale for this request:**

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## Previous Medications

Please list all previous medications tried and failed for this condition:

| Name of Medication | Reason for Failure or Inability to Use | Date |
|---|---|---|
| | | |
| | | |
| | | |

## Previous Tests and Procedures

Please list all previous tests and procedures attempted here:

| Procedure | Findings | Date |
|---|---|---|
| | | |
| | | |
| | | |

## Additional Notes and Attachments

Please provide any additional notes or comments you'd like to share below:

☐ Please check if attaching relevant clinical information

Thank you for your time. We'll process your request as soon as it is received.