Request for Prior Authorization Form

Smi+hRx

Submit requests to:

SmithRx
PO Box 77864
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**

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

Prescriber Signature (required): Date:

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