Hughes Family Practice
Prior Authorization Request Form

Patient Name:	
Date of Birth:	

Date Requested:	
Fee:	
Paid on:	
Office Staff Initials	
Office ICD-10 Dx:	

Insurance Pharmacy Benefit Manager:	
Pharmacy ID #:	

(ex: Caremark, Optum, Prime Therapeutics, etc)

Medication Requested:

Reason for this class of medication (Diagnosis)

Please briefly explain why you are requesting this specific medication

Please list any other medications you have tried to address this problem			
Medication	Dates		Reason you no longer take it
	Start	Stop	

Other Info:	