Banner
University Family Care

Pharmacy Prior Authorization Request Form

Note: To ensure that prior authorizations are reviewed promptly, submit request with current clinical notes and relevant lab work.

Fax completed form to:
(833) 812-0181

Date: _____ Request Type: ❑ Standard ❑ Expedited

HEALTH PLAN

❑ **Banner – University Family Care (ACC)**

❑ **Banner – University Family Care (ALTCS)**

MEMBER INFORMATION

Name: Last	First	MI
Date of Birth:	**Member ID#:**	**Phone:**

REQUESTING PROVIDER INFORMATION

First & Last Name:	**NPI:**
Provider's Address:	**City, State & Zip:**
Phone:	**Fax:**

MEDICAL INFORMATION / MEDICATION REQUEST

Medication:	**Quantity:**	**Dosing Regimen:**	**Duration of Therapy:**

Administered: ❑ Doctor's Office ❑ Dialysis Center ❑ By Patient ❑ Other (specify):

Relevant Diagnoses:

Reason for Exception:

New Start with This Medication: ❑ Yes ❑ No If No, Date of First Dose:

Alternative Medication(s) Tried & Reason(s) for Failure:

For Office Use Only:

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