PRIOR AUTHORIZATION REQUEST - INJECTABLE MEDICATION

Please complete all applicable fields in this form. Fax the completed form to Pharmacy Services at 877-232-5976.

PATIENT INFORMATION

Patient name:

Patient ID:

Date of birth (MM/DD/YY):

Gender: ☐ Male ☐ Female

PRESCRIBER INFORMATION

Physician name:

Specialty:

Phone:

Fax:

Contact person:

AUTHORIZATION INFORMATION

Diagnosis:

Diagnosis code:

Referring physician:

Who is administering?

Location of administration:

Medication and dose requested	Start/end dates of service		J-Code/HCPCS codes*	Number of visits

MEDICAL RATIONALE FOR USE**

SPECIAL CONSIDERATIONS

Prescriber Signature

Date

*Please ensure that the correct J-Code is used. This will expedite processing for your request.
**If medication/therapy prescribed requires prior authorization, provide rationale for use.

Colorado ACCESS

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