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**EXPRESS SCRIPTS®**

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BL0345

Bloomington, MN 55439

Prior Authorization Phone # 1-800-417-8164

**Prior Authorization Request Form**

**FAX to ESI: 877-837-5922**

**Please Note:** If the following information is NOT filled in completely, correctly or legibly, the authorization review **will be delayed**. Please allow 24 hours for processing.

**Insurance Company** \_\_\_\_\_

**Patients Prescription ID#** \_\_\_\_\_

**Patient Full Name** \_\_\_\_\_

**Patient Date of Birth** \_\_\_\_\_

**Medication Requested** \_\_\_\_\_

**Quantity Requested** \_\_\_\_\_ **for** \_\_\_\_\_ **days supply**

**Physician Name (please print clearly)** \_\_\_\_\_

**Physician NPI/DEA number (required)** \_\_\_\_\_

**Physician Specialty** \_\_\_\_\_

**Physician Phone** \_\_\_\_\_ **Physician Fax** \_\_\_\_\_

**PLEASE DOCUMENT: Diagnosis, Indication, Medical History and any other additional information which the Physician considers important to this review:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE DOCUMENT: Other Medications/Therapies tried (including duration and reason for failure):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Physician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Office Contact Person** \_\_\_\_\_

Any further or additional information related to this request should be included and attached to this form.