

# ARIZONA STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

## SECTION I – SUBMISSION

Subscriber Name:	Phone:	Fax:	Date:
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## SECTION II – REASON FOR REQUEST

<b>Review Type:</b> <input type="checkbox"/> Non-Urgent <input type="checkbox"/> Urgent	Clinical Reason for Urgency:	
<b>Request Type:</b> <input type="checkbox"/> Initial <input type="checkbox"/> Extension/Renewal/Amendment	Prev. Auth. #:	

## SECTION III – REVIEW

**Expedited/Urgent Review Requested:** By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient’s ability to regain maximum function.

Signature of Prescriber or Prescriber’s Designee: \_\_\_\_\_

## SECTION IV – PATIENT INFORMATION

Name:	Phone:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Member Name (if different from Section I):	Member ID #:	Group Name or Number:	

## SECTION V – PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Service Care Provider’s Name:	
Requesting Provider’s Signature and Date (if required):		Phone:	Fax:

## SECTION VI – SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version___)	Code

Inpatient    Outpatient    Provider Office    Observation    Home    Day Surgery    Other: \_\_\_\_\_

Physical Therapy    Occupational Therapy    Speech Therapy    Cardiac Rehab    Mental Health/Substance Abuse

Number of Sessions: \_\_\_\_\_ Duration: \_\_\_\_\_ Frequency: \_\_\_\_\_ Other: \_\_\_\_\_

Home Health:                      Order Attached?    Yes    No                      Nursing Assessment Attached?    Yes    No

Number of Visits: \_\_\_\_\_ Duration: \_\_\_\_\_ Frequency: \_\_\_\_\_ Other: \_\_\_\_\_

## SECTION VII – CLINICAL DOCUMENTATION (Attach additional documentation as needed)

# ARIZONA STANDARDIZED PRIOR AUTHORIZATION REQUEST FOR MEDICATION, DME, AND MEDICAL DEVICE

## SECTION I – SUBMISSION

Subscriber Name:	Phone:	Fax:	Date:
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## SECTION II – REASON FOR REQUEST

<b>Check one:</b>	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Continuation/Renewal Request
<b>Reason for request: (check all that apply)</b>		<input type="checkbox"/> Prior Authorization
<input type="checkbox"/> Step Therapy, Formulary Exception		<input type="checkbox"/> Medical Device
<input type="checkbox"/> Quantity Exception		<input type="checkbox"/> Durable Medical Equipment (DME)
<input type="checkbox"/> Specialty Drug		<input type="checkbox"/> Other (please specify) _____

## SECTION III – REVIEW

<input type="checkbox"/>	<b>Expedited/Urgent Review Requested:</b> By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.
Signature of Prescriber or Prescriber's Designee: _____	

## SECTION IV – PATIENT INFORMATION

Name:	Phone:	DOB:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Address:	City:	State:	ZIP Code:	
Subscriber Name (if different from Section I):	Member ID #:	Group Name or Number:		
BIN # (if available):	PCN (if available):	Rx ID # (if available):		

## SECTION V – PRESCRIBER/ORDERING PROVIDER INFORMATION

Name:	NPI #:	Specialty:		
Address:	City:	State:	ZIP Code:	
Phone:	Fax:	Office Contact Name:	Contact Phone:	

## SECTION VI – PRESCRIPTION DRUG INFORMATION

*(If this is a compound drug, identify all ingredients in Section VI, below.)*

Requested Drug Name:				
Strength:	Route of Administration:	Quantity:	Days' Supply:	Expected Therapy Duration:
To the best of your knowledge this medication is:				
<input type="checkbox"/> New therapy <input type="checkbox"/> Continuation of therapy (approximate date therapy initiated: _____)				
For Provider Administered Drugs Only:				
HCPCS Code: _____ NDC #: _____ Dose Per Administration: _____				

# ARIZONA STANDARDIZED PRIOR AUTHORIZATION REQUEST FOR MEDICATION, DME, AND MEDICAL DEVICE

## SECTION VII — PRESCRIPTION COMPOUND DRUG INFORMATION

Compound Drug Name:					
Ingredient	NDC #	Quantity	Ingredient	NDC #	Quantity

## SECTION VIII — PRESCRIPTION DME or MEDICAL DEVICE INFORMATION

Requested DME or Medical Device Name:	Expected Duration of Use:	HCPCS Code (if applicable):
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## SECTION IX — PATIENT CLINICAL INFORMATION

Patient's diagnosis related to this request:	ICD Version:	ICD Code:
Patient's diagnosis related to this request:	ICD Version:	ICD Code:

Drugs patient has taken for this diagnosis: *(Provide the following information to the best of your knowledge)*

Drug Name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason for Failure, or Allergy

Drug Allergies:	Height (if applicable):	Weight (if applicable):
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Relevant laboratory values and dates (attach or list below):

Date	Test	Value

## SECTION X — JUSTIFICATION (Provide or attach any additional justification here: Notes, Treatment plans, lab/test results, etc)