

TeamstersCare Medication Prior Authorization Form



- ❖ Complete and fax to 617-241-5025.
- ❖ Standard response time is 3 to 5 business days from date received.

PATIENT INFORMATION

Patient Name:

Date of Birth:

TeamstersCare ID#:

Patient Address:

Patient Phone:

PROVIDER INFORMATION

Provider Name:

Contact Person (If different than prescriber):

Office Phone:

Office Fax:

MEDICATION INFORMATION

Medication Requested: (specify name, strength, dosing)

Diagnosis Related to Use:

Duration of Therapy:

Other Alternatives Tried and Failed:

Any Additional Pertinent Information:

Doctor's Signature:

Date:

FOR TEAMSTERSCARE USE ONLY

Eligibility Verified

Program: Active/NCH ERMP RRX

Medication Requires PA

Prior PA? Yes No If Yes, Date:

Form Complete/Legible

Authorized Pended Denied

Patient Notified By: Date:

Letter Sent By: Date:

Notes:

Reviewer :

Date: