TeamstersCare General 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 | | Notes: | |
| Program: Active/NCH ☐ ERMP ☐ R | RX□ | | |
| Medication Requires PA □ | | | |
| Prior PA? Yes□ No □ If Yes, Date: | | | |
| Form Complete/Legible | | | |
| Authorized ☐ Pended ☐ De | nied 🗆 | | |
| Patient Notified By: | Pate: | | |
| Letter Sent □ By: | Date: | Reviewer : | Date: |