## **TeamstersCare Specialty Medication Prior Authorization Form**

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

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PATIENT INFORMATION				
Patient Name:				
Date of Birth:	TeamstersCare ID#:			
Patient Address:				
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Patient Phone:				
PROVIDED INCORNATION				
PROVIDER INFORMATION Provider Name:	Dogradi	Specialty	Board Certified? Yes	
Provider Name.	Degree:	Specialty:	No	
Office Phone:		Office Fax:		
Office Priorie.		Office Fax.		
MEDICAL INFORMATION				
Diagnosis (and significant history):				
Any Additional Pertinent Information	n:			
MEDICATION INFORMATION  Nedication Degrees de la region de la companyation de thomas de la companyation				
Medication Requested: (specify name, strength, dosing, and duration of therapy)				
Other alternatives tried and failed:				
SIGNATURE				
Doctor's Signature		Date		
FOR TEAMSTERSCARE USE ONLY				
Eligibility Verified	-	Notes:		
Program: Active ☐ ERMP ☐ RR	K 🗆	1		
Prior PA? Yes□ No□ If Yes, Date:				
Form Complete/Legible				
		_		
Authorized  Pending	Denied			
Patient Notified D. Bur	Date:	-		
Patient Notified ☐ By:  Letter Sent ☐ By:	Date: Date:	-		
Letter Jent L by.	Date.			
		Reviewer :	Date:	