

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.

PATIENT INFORMATION			
Patient Name:			
Date of Birth:		TeamstersCare ID#:	
Patient Address:			
Patient Phone:			
PROVIDER INFORMATION			
Provider Name:	Degree:	Specialty:	Board Certified? Yes _____ No _____
Office Phone:		Office Fax:	
MEDICAL INFORMATION			
Diagnosis (and significant history):			
Any Additional Pertinent Information:			
MEDICATION INFORMATION			
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 <input type="checkbox"/>	Notes: Reviewer : _____ Date: _____
Program: Active <input type="checkbox"/> ERMP <input type="checkbox"/> RRX <input type="checkbox"/>	
Prior PA? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Date: _____	
Form Complete/Legible <input type="checkbox"/>	
Authorized <input type="checkbox"/> Pending <input type="checkbox"/> Denied <input type="checkbox"/>	
Patient Notified <input type="checkbox"/> By: _____ Date: _____	
Letter Sent <input type="checkbox"/> By: _____ Date: _____	