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: **Please send a copy of most recent office visit notes**			
SIGNATURE			
Provider's Signature	**Date**		

FOR TEAMSTERSCARE USE ONLY	
Eligibility Verified ☐	**Notes:**
Program: Active ☐ ERMP ☐ RRX☐	
Prior PA? Yes☐ No ☐ If Yes, Date:	
Form Complete/Legible ☐	
Authorized ☐ Pending ☐ Denied ☐	
Patient Notified ☐ By: Date:	
Letter Sent ☐ By: Date:	**Reviewer :** **Date:**