Banner Medicare Advantage
Pharmacy Prior Authorization Request Form

Note: **To ensure that prior authorizations are reviewed promptly, submit request with current clinical notes and relevant lab work.**

Fax completed form to: (833) 951-1682

Date: _____

Request Type: ❑ Standard (72 hours) ❑ Expedited (24 hours)

HEALTH PLAN	
❑ Banner Medicare Advantage DUAL (DSNP)	❑ Banner Medicare Simple Rx (PDP)
❑ Banner Medicare Advantage Prime (HMO)	❑ Banner Medicare Classic Rx (PDP)
❑ Banner Medicare Advantage Plus (PPO)	❑ Banner Medicare Premier Rx (PDP)

MEMBER INFORMATION		
Name: Last	First	MI
Date of Birth:	**Member ID#:**	**Phone:**

REQUESTING PROVIDER INFORMATION	
First & Last Name:	**NPI:**
Phone:	**Fax:**

MEDICAL INFORMATION / MEDICATION REQUEST			
Medication:	**Quantity:**	**Dosing Regimen:**	**Duration of Therapy:**
Relevant Diagnoses:			
Reason for Exception:			
Alternative Medication(s) Tried & Reason(s) for Failure:			

For Office Use Only:

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