PASSPORT HEALTH PLAN

UTILIZATION MANAGEMENT MEDICATION AUTHORIZATION REQUEST FORM

Complete this entire treatment plan to avoid delays in processing your request.
Fax completed request to: (502) 585-7989

Today's Date: _____ Member Name: _____ PHP ID: _____

Medication Requested: _____ J Code: _____

Administrative Code/CPT Code: _____

Dosage: _____ Frequency: _____ Requested Date of Service: _____

Diagnosis/ICD9: _____ Height: _____ Weight: _____

Clinical Information: (Including Labs pertinent to drug)

_____

_____

_____

Current/Previous Medications for above diagnosis:

NAME OF DRUG	DOSAGE	DATE STARTED
_____	_____	_____
_____	_____	_____
_____	_____	_____

Provider Information:

Requesting Provider Name: _____ PHP ID Number: _____

Facility: _____ PHP ID Number: _____

Contact Person: _____ Telephone Number: _____ Fax Number: _____