Please Note: Medical Necessity Prior Authorization may be utilized to override both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

Catalyst Rx
9525 Hillwood Dr., Suite 100
Las Vegas, NV 89134
Customer Service: 1-888-869-4600

PRIOR AUTHORIZATION FORM

Initials_____

Date: _____/_____/_____ **Plan/Employer Name: _____**

Patient Name: _____
First Middle Last

Member ID#: _____ **Date of Birth: _____**

****PLEASE COMPLETE & FAX TO CATALYST RX @ 1-888-852-1832****

DRUG REQUEST:_____
DRUG NAME DRUG STRENGTH QUANTITY DIRECTIONS FOR USE

ICD-9 Code: _____

Diagnosis: _____

Duration of Therapy: _____

Please List Alternative Therapies that Have Been Attempted or Other Pertinent Information Below:

_____

_____

_____

Physician Signature: _____ **Date: _____/_____/_____**

Printed Name: _____ **Phone #: _____**

Action Needed: ☐ Urgent ☐ For Review **Fax #: _____**

**********FOR INTERNAL USE ONLY**********

Date: _____/_____/_____ ☐ **Approved: Duration_____thru_____**
Pharmacy Contacted: ☐ Yes ☐ No ☐ **Denied**
Completed by: _____
Comments:
_____

_____

Reviewed by: _____Noted by: _____

Reason for PA Request (Max $, QL, etc.) _____