

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.) _____

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