rightway

Rightway
Phone: 888.665.1885
Fax: 888.498.1038

# GENERAL AUTHORIZATION FORM
## Prior Authorization, Step Therapy & Quantity Limit Exception

| | |
|---|---|
| ☐ Standard Request<br>☐ Expedited Request | If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. |

## Demographics

| Patient Information | | Prescriber Information | |
|---|---|---|---|
| Patient Name: | | Prescriber Name: | |
| DOB: | ☐ Male<br>☐ Female | NPI#: | Specialty: |
| Pharmacy Benefits ID#: | | Phone: | Fax: |
| Pharmacy Name: | Pharmacy Phone: | Office Contact: | Direct Phone # or Ext: |

## Medication Information

| | | |
|---|---|---|
| Drug Requested: | Strength: | Frequency: |
| Quantity Dispensed: | Day Supply: | ☐ Generic<br>☐ Brand Necessary |

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

| | | |
|---|---|---|
| ☐ New medication<br>☐ Continuation of therapy | Start Date: | If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy. |

## Billing Information

| | | |
|---|---|---|
| ☐ Billed by PHARMACY delivered to the member or provider for administration. | ☐ Billed under MEDICAL benefit.<br>J CODE:_____<br>ICD-10 Code:_____ | Place of Administration:<br>☐ Physician's Office<br>☐ Hospital/Clinic<br>☐ Patient Home |

## Clinical Information

| | |
|---|---|
| Diagnosis: | Date Diagnosed: |

## History of Medications Used to Treat Above Condition

☐ No other medications have been used to treat this condition

| Medication | Strength | Frequency | Dates of Therapy | | Reason for Discontinuing |
|---|---|---|---|---|---|
| | | | Start | End | |
| | | | | | |
| | | | | | |

## Please provide any additional information which should be considered in the space below:

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**Attestation:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification: _____**

**Date: _____**