Medical Necessity – Washington Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID	
Pharmacy name	Pharmacy NPI	Telephone number	Pharmacy name
Prescriber	Prescriber NPI	Telephone number	Prescriber
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of therapy? ☐ Yes ☐ No
   If yes:
   - What date did patient last receive this drug?
   - Is continuation of therapy based on being established on samples or manufacturer coupons?
     ☐ Yes ☐ No
   - Does patient have clinical documentation demonstrating disease stability or a positive clinical benefit?
     ☐ Yes ☐ No

2. What is the patient's diagnosis and the date of diagnosis for which this drug has been prescribed?

3. Is the requested drug prescribed in accordance with FDA labeling or prescribed for a condition supported in compendia (classified as strength of evidence category A or B and strength of recommendation class 1 or 2a)?
   ☐ Yes ☐ No. Explain:

4. Is the requested drug prescribed within the age, dose and dosing frequency limits in FDA labeling or supported in compendia? ☐ Yes ☐ No. Explain:

5. Has patient had treatment with first-line therapies recommended in North American or World Health Organization (WHO) evidence-based practice guidelines*, FDA-approved or compendia supported therapeutic alternatives, for the treatment of patient's condition, that was ineffective, contraindicated or not tolerated?
   ☐ Yes. List each medication, duration and outcome of trial:

Medication Name	Duration of trial	Outcome of trial

* Other guidelines may be used on a case-by-case basis when submitted with the request.

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☐ No. Explain why other first-line therapies have not been tried:

6. Other:

Chart notes, labs and all diagnostic tests confirming diagnosis are required with this request

Prescriber signature	Prescriber specialty	Date