PRIOR AUTHORIZATION REQUEST FORM FOR UNINSURED AND DISTRICT CARES PATIENTS ONLY

Health Care District	FAX COMPLETED FORMS TO: (561) Important: Use one request form per of Incomplete forms will not be process	Irug
Medical Record Number	Member Date of	Birth (MM/DD/YYYY)
Member Name (Last, First)		
Prescriber Name (Last, First)		
Prescriber NPI#	Prescriber Phone#	Prescriber Fax#
Drug Name		Strength
Drug Name		Strength
Drug Name Drug Name Directions		Strength Quantity

Please explain why patient cannot utilize a formulary medication. Please include a list of medications that the patient has previously tried, including doses, durations, and reasons for discontinuation:

HCD Clinic Pharmacy Location Member Utilizes (Please circle one location)

West Palm Beach	Lantana	Delray Beach	Belle Glade	Mangonia Park
1150 45 th Street	1250 Southwinds Dr.	200 Congress Park Dr	39200 Hooker Hwy	2051 45 th St Ste 300
561-209-2577	561-209-2575	561-209-2570	561-209-2580	561-209-2573

Provider Signature

Date (MM/DD/YYYY)									

For questions regarding completion or processing of this form, please contact Health Care District Pharmacy Prior Authorization Department at 561-804-5600 x291202.

The approval for this request is subject to member active eligibility status/criteria and specific plan coverage and limitations.

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