# ARIZONA STANDARDIZED PRIOR AUTHORIZATION REQUEST FOR MEDICATION, DME, AND MEDICAL DEVICE

**SECTION I – SUBMISSION**

| Subscriber Name: | Phone: | Fax: | Date: |
|---|---|---|---|
| | | | |

**SECTION II — REASON FOR REQUEST**

| **Check one:** | ☐ Initial Request | ☐ Continuation/Renewal Request |
|---|---|---|

**Reason for request: (check all that apply)**

☐ Step Therapy, Formulary Exception

☐ Quantity Exception

☐ Specialty Drug

☐ Prior Authorization

☐ Medical Device

☐ Durable Medical Equipment (DME)

☐ Other *(please specify)*_____

**SECTION III — REVIEW**

☐ **Expedited/Urgent Review Requested:** By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Signature of Prescriber or Prescriber's Designee: _____

**SECTION IV — PATIENT INFORMATION**

| Name: | Phone: | DOB: | ☐ Male ☐ Female | |
|---|---|---|---|---|
| Address: | City: | | State: | ZIP Code: |
| Subscriber Name (if different from Section I): | Member ID #: | Group Name or Number: | | |
| BIN # (if available): | PCN (if available): | Rx ID # (if available): | | |

**SECTION V — PRESCRIBER/ORDERING PROVDER INFORMATION**

| Name: | | NPI #: | Specialty: | |
|---|---|---|---|---|
| Address: | | City: | State: | ZIP Code: |
| Phone: | Fax: | Office Contact Name: | Contact Phone: | |

**SECTION VI — PRESCRIPTION DRUG INFORMATION**

*(If this is a compound drug, identify all ingredients in Section VI, below.)*

| Requested Drug Name: | | | | |
|---|---|---|---|---|
| Strength: | Route of Administration: | Quantity: | Days' Supply: | Expected Therapy Duration: |

To the best of your knowledge this medication is:

☐ New therapy ☐ Continuation of therapy (approximate date therapy initiated:_____)

For Provider Administered Drugs Only:

HCPCS Code:_____ NDC #:_____ Dose Per Administration: _____

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**SECTION VII — PRESCRIPTION COMPOUND DRUG INFORMATION**

| Compound Drug Name: | | | | | |
|---|---|---|---|---|---|
| Ingredient | NDC # | Quantity | Ingredient | NDC # | Quantity |
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**SECTION VIII — PRESCRIPTION DME or MEDICAL DEVICE INFORMATION**

| Requested DME or Medical Device Name: | Expected Duration of Use: | HCPCS Code (If applicable): |
|---|---|---|
| | | |

**SECTION IX — PATIENT CLINICAL INFORMATION**

| Patient's diagnosis related to this request: | ICD Version: | ICD Code: |
|---|---|---|
| Patient's diagnosis related to this request: | ICD Version: | ICD Code: |

Drugs patient has taken for this diagnosis: *(Provide the following information to the best of your knowledge)*

| Drug Name | Strength | Frequency | Dates Started and Stopped or Approximate Duration | Describe Response, Reason for Failure, or Allergy |
|---|---|---|---|---|
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| | | | | |

| Drug Allergies: | Height (if applicable): | Weight (if applicable): |
|---|---|---|
| | | |

Relevant laboratory values and dates (attach or list below):

| Date | Test | Value |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**SECTION X — JUSTIFICATION (Provide or attach any additional justification here: Notes, Treatment plans, lab/test results, etc)**