Independent Health

REQUEST FOR PHARMACY DRUG AUTHORIZATION

Member Name: _____ DOB: _____

Member ID number: _____ Date: _____

MD Name: _____ MD NPI: _____

MD Address: _____ MD TIN: _____

MD Fax Number: _____ MD Phone Number: _____

Contact Person (if additional info is needed): _____ Contact Person Phone Number: _____

Is this an appeal to a previously denied request *(please check one)***?** **YES** ☐ **NO** ☐

Drug Requested Name, Strength & Form: _____

Quantity Prescribed: _____

Expected Duration: _____

Directions for use: _____

Diagnosis: _____

Is this a renewal *(please check one)***?** **YES** ☐ **NO** ☐ **If YES, date drug was initiated** _____

Who will administer this medication *(please check one)***?** **MEMBER** ☐ **PROVIDER** ☐

Reason(s) Drug is Requested (please provide all relevant clinical information to support your request, you may attach additional documentation if needed):

Other Formulary Drugs tried:

Drug Name	Dates Tried	Reason for Failure

MD Signature: _____ **Date**: _____

If you have any questions regarding this request, please contact the pharmacy department at (716) 631-2934 or (800) 247-1466 x5311 between the hours of 8:00 am and 5:00 pm Monday – Friday.

Form may be mailed to:
Independent Health Association
Attn: Pharmacy Department
511 Farber Lakes Drive
Buffalo, NY 14221

or Faxed to:
(716) 631-9636, **OR** (716) 631-0149**, OR** (800) 273-7397

Revised September 2023