INJECTABLE MEDICATION PRIOR AUTHORIZATION FORM

Please complete all applicable fields in this form. Fax the completed form to Colorado Access Pharmacy Services at 720-744-5127. Call 1-800-511-5010 for questions.

PATIENT INFORMATION

Last Name

First Name

Patient ID

DOB (MM/DD/YY)

Sex: ☐ Male ☐ Female

PRESCRIBER INFORMATION

Physician Name

Specialty

Office Phone

Office Fax

Contact Person

AUTHORIZATION INFORMATION

Diagnosis:	Diagnosis Code:
Referring Physician:	

Item Requested	Start & End Dates of Service	J-Code / HCPCS Codes	# of visits

MEDICAL RATIONALE FOR USE**

SPECIAL CONSIDERATIONS

Prescriber Signature:_____ Date:_____

*Please ensure that the correct J-Code is used. This will expedite processing for your request.
**If medication/therapy prescribed requires prior authorization, provide rationale for use.

SERVICE AUTHORIZATION FORM

Please complete all applicable fields on this form.
You may call us at 1-800-511-5010 or 303-751-9005. Fax this form to 720-744-5127

#1

Today's Date: _____

Member's Name: _____ State ID: _____ DOB: _____

Member Phone #: _____ Language(s): _____

Does the member have other insurance? ☐ No ☐ Yes If yes, ☐ Medicare ☐ Other _____

Requesting Provider: _____ Specialty: _____

Person Completing Form: _____ Office Phone #: _____ Office Fax #: _____

#2

ICD-9/Dx: _____

HCPCS/J code(s): _____

Outpatient Inpatient State Date: _____ State Date: _____ # of visits requested: _____

Medical Rationale for Use _____

_____

_____

_____

_____

Please note: Don't forget to attach clinical notes with request to avoid processing delays

Prescriber Signature:_____ Date:_____