IPM Integrated Prescription Management

7815 N Palm Ave
Suite 400
Fresno, CA 93711

Prior Authorization Request Form for Prescription Drugs

☐ Non-Urgent Request ☐ Urgent Circumstances (please include rationale in Section VI)

Fax this completed form to 800.476.2691.
This form is to be used by prescribers only.

I. Prescriber Information (please print)

Prescriber Name:	**Office Contact:**
Prescriber NPI:	**Specialty:**
Phone:	**Fax:**

II. Member Information (please print)

Member name:	**Phone:**
Member ID #:	**Date of Birth:**

Address: **City:** **State:** **Zip:**

Required to confirm address for any correspondence related to prior authorization(s)

Medication allergies:

III. Drug Information (one medication per request form)

Drug name & strength:

Directions:

Diagnosis (ICD-10) relevant to this request:

IV. Medication history for this diagnosis

A. Is member currently treated with this medication? ☐ Yes. For how long? _____ ☐ No

B. Expected Length of Therapy?

V. Previous treatment and outcomes

Note: Confirmation of use will be made from member claim history. Prior use of formulary drugs is part of the exception criteria. The IPM formularies are located on the IPM website at www.rxipm.com.

Drug name & strength	Dates of therapy	Reason for discontinuation

VI. Clinical rationale for medication/urgent circumstances

Prescriber/Agent Signature:	**Date:**

If marked as **urgent**, I attest this is an urgent case, meaning that an expedited (fast) determination is necessary to prevent serious threat to life, health, or the body's ability to regain maximum function; or is needed to manage severe pain.

Information on this form is Protected Health Information (PHI) and subject to all privacy and security under HIPAA.

Appropriate clinical information (including lab reports, when appropriate) to support the request on the basis of medical necessity must be submitted. IPM is unable to evaluate any request without office notes.