MEDICAL NECESSITY REVIEW **PLEASE FAX FORM TO MedBen RX: 740-522-5002**

Request for Prior Authorization for coverage of an excluded/limited drug. The Plan may direct site of care.

☐ **Urgent Review*** ☐ **Standard Review**

***Urgent Review criteria:** A request involving urgent care is one in which the time periods for making a non-urgent prescription medication determination could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or, in the opinion of the physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the prescription treatment that is the subject of this prior authorization.

MedBen Rx pharmacy solutions
1975 Tamarack Road
P.O. Box 1099 Newark, Ohio 43058-1099
(800) 686-8425 Fax:740-522- 5002
Email:medben@medben.com

MEMBER/PATIENT INFORMATION ☐ Check if member is a patient at the Wood County Community Health Center				
Name:			SSN:	Sex: ☐ Male ☐ Female
Address:			Date of Birth:	
City:	State:	Zip code:	Phone:	
Medication Allergies:	Preferred Pharmacy Name:		Pharmacy Phone:	

PROVIDER INFORMATION				
Provider Name:	NPI#:		Specialty:	
Address:			Office contact name:	
City:	State:	Zip code:	Office Phone:	Office Fax:

MEDICATION INFORMATION			
Drug Name:	Strength:	Dose:	Directions (Sig):
Duration Days: Months:	Quantity:	Refills:	Diagnosis:

☐ Injectable/Infusion: ☐ Self-administered ☐ Supervised Injection Facility: Name | Facility NPI#

Is the Patient currently treated on this medication? ☐ No ☐ Yes If "Yes", How long_____

CLINICAL INFORMATION -- SUBMIT MOST RECENT OFFICE VISIT NOTES WITH FORM.

What medication(s) has the patient tried and failed?

Are there any supporting labs or test results? *(Please specify)*

Are there any other comments or information the physician feels is important to this review:

Provider Signature:_____ Date:_____

By signature, the Prescriber (or agent of the prescriber) confirms that all information provided is accurate.

*****In order for your request to be considered, all sections of this form must be completed. Most reviews will be concluded within 72 hours unless additional information is required or additional clinical review is needed.*****