PRIOR AUTHORIZATION FORM
General Exception - Commercial/Medicaid

Unless otherwise indicated below, authorization quantities are limited to the manufacturer recommended dosage

SCRIPIUS
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P.O. Box 30192 Salt Lake City, UT 84130

Complete online at www.selecthealth.org/pa or fax back to: 801-442-3006
For questions or clarifications, call: 800-442-3129

Patient Information	
Patient's Name:	Patient's Date of Birth:
Patient's ID:	Patient's Phone #:
Diagnosis Code(s):	
Requesting Provider Information	
Name:	Phone #:
NPI/DEA:	Fax #:
Address:	Supervising Physician (if requesting provider bills under a different provider)
	Name:
	NPI/DEA:
Servicing Provider Information (if different than requesting provider)	
Name of provider or facility:	Phone number:
NPI/DEA:	Address:

Drug Name and Strength:	Directions / SIG:

Q1. What is the patient's diagnosis?

Q2. What medication is being requested? Please include strength, dosage form, and directions for use.

Q3. What alternative medications have been attempted?

Q4. Has the patient failed previous treatment and shown intolerance, or has a contraindication to the covered alternatives? If yes, please describe below and attach chart notes.

Q5. For members on RxCore policies, is this request for maintenance (90 day supply) dosing?

☐ Yes ☐ No ☐ N/A

Q6. Additional Comments:

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

Prescriber Signature

Date