



CUSTOM PRESCRIPTION MANAGEMENT

PRIOR AUTHORIZATION REQUEST

SECTION 1

Employer/Health Plan Name _____ **Serve You** Group Number _____
 Cardholder's Name _____ Cardholder Number _____
 Patient's Name _____ Patient's Date of Birth ____/____/____

SECTION 2 *(To be completed by Physician)*

Medication Authorization (Complete a separate form for each prescription.)

Drug Prescribed _____ Strength _____
 Dosage Form _____ Length of Therapy _____
 Diagnosis _____ This drug is medically necessary due to _____

Physician Name *(please print)* _____ Phone _____
 Physician Signature _____ Date _____

SECTION 3 *(To be completed by the Plan Sponsor, if required)*

Drug _____ Strength _____ Dosage Form _____
 Days Supply Per Fill _____ If extended day supply, number of copays to apply _____
 Exception to Benefit Design: _____

One time only For one year Other: _____

Effective date for this authorization ____/____/____ Ending date for this authorization ____/____/____

Authorized Signature: _____ Date _____

SECTION 4 *(To be completed by Serve You)*

This authorization is due to: MEDICAL NECESSITY OTHER _____

Effective date for this authorization ____/____/____ Ending date for this authorization ____/____/____

Prior Authorization Entered By _____ Date _____

Serve You will enter all exceptions and prior authorizations in accordance with the information supplied above.
Serve You is not responsible for errors or omissions resulting from incorrect or missing information.

Upon completion of Section 1, Section 2 or Section 3, please mail, fax or email completed form to:

Serve You
 Attention: Authorizations
 9051 West Heather Avenue
 Milwaukee, WI 53224

FAX: 414-410-8181 Attention: Authorizations