



THE HAND-CRAFTED PBM

# PRIOR AUTHORIZATION REQUEST

## SECTION 1

Group Number \_\_\_\_\_

Patient Name \_\_\_\_\_

ID Number \_\_\_\_\_

Patient's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

## SECTION 2 *(Complete all applicable fields)*

Medication Authorization (Please complete a separate form for each prescription.)

Drug Prescribed \_\_\_\_\_ Strength \_\_\_\_\_

Dosage Form \_\_\_\_\_ Length of Therapy \_\_\_\_\_

Diagnosis \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_

This drug is medically necessary due to \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prescriber Name *(please print)* \_\_\_\_\_ Phone \_\_\_\_\_

Prescriber Signature \_\_\_\_\_ Date \_\_\_\_\_

## SECTION 3 *(To be completed by Serve You)*

Approved  Not Approved

Effective date for this authorization \_\_\_\_/\_\_\_\_/\_\_\_\_ Ending date for this authorization \_\_\_\_/\_\_\_\_/\_\_\_\_

Prior Authorization Entered By \_\_\_\_\_ Date \_\_\_\_\_

**Upon completion of the form, please return it using any one of the following methods:**

**FAX**  
414-410-8181  
Attention: Authorizations

**MAIL**  
Serve You  
Attention: Authorizations  
10201 Innovation Drive, Suite 600  
Milwaukee, WI 53226

**EMAIL**  
manual.eligibility@serve-you-rx.com