

Phone: (800) 303-9626 Fax: (844) 807-8455

NOTE: Please ensure completion of this form in its entirety and attach required documentation for an accurate review.

PATIENT INFORMATION		PRESCRIBER INF	FORMATION
Full Name:  ID:  Date of Birth:  Phone:  Allergies:	Full Name: Specialty: Office Contact Pers Office Phone: Office Fax:	on:	NPI #:
		Emagn	onov.
Request is for: <b>Medication Name:</b> ☐ Initiation of therapy  ☐ If so, Start date:		rrequ	tency:
☐ Continuation of therapy If so, Start date:		1	If YES, attach medical records
DIAGNOSIS INFORMATION			
Has the patient tried and failure prior medications? ☐ Yes  1) Medication Name: Dose:  2) Medication Name: Dose:	CAL INFORMATION  □ No If yes, How many  Frequency:  Frequency:	y? Start date: Start date:	End Date:End Date:
3) Medication Name: Dose: Describe failure of therapy: □ No response □ Partial respo		Start date:	End Date:
*Please attach the most recent clinical notes or supporting documentation*			
I attest that this information is accurate and true, and that documentation supporting this information was <u>attached</u> and is available for review if requested by MetroPlus Health Plan or the benefit plan sponsor.  X			
Prescriber or Authorized Signature			Date (mm/dd/yy/)
Please complete the following contact information in case additional information is needed.			
Office Contact Person: Conta	ct Phone:	Ext	#:
Date Form Completed and Faxed:			
MetroPlus Health Plan			

**Pharmacy Utilization Management Department** 50 Water Street 7th floor, New York, NY 10004

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