Medication PRIOR AUTHORIZATION Request Form

Submit to: bhmedunitsupervisorystaff@lifepathsystems.org

Consumer's Name: (First, Middle Initial, Last)____

Member's LifePath Systems ID Number:______________________ Date of Birth:____/____/_____

Physician (Full Name):__________________________________Contact Person: ______________________

Physician's Address: ____

Phone Number:____Fax Number: ________________________

Medication Requested:________________________________ Medication Strength: _______________

Tabs per day/ Frequency____________________________ Medication Allergies:___________________

Request for Dosage Override ___ No ___ Yes If Yes, Dose Requesting: ___________________________

Diagnosis treating with this Medication: ____

Has the member been on this medication previously? ___ No ___ Yes If yes for how long: _____________

If the member is currently taking this medication, identify the setting the member was stabilized in on this medication:
___ State Hospital ___ Community Hospital __ Outpatient Setting ___ Other: ______________

Previous Medication History:

____
Drug/dose/frequency Dates of therapy Reason for Discontinuing

____
Drug/dose/frequency Dates of therapy Reason for Discontinuing

Rationale for the request: ____
____
____
____
____

Physician's Signature:____Date:_____/_____/ _____

To be completed by LPS Medical Director

_____ DENIED: Comments: ____

_____APPROVED: From: _____________ To: ______________

Additional Comments: ____

____

Medical Director's Signature:______________________________ Date:____/______/ ______

IPM Over-ride notification Completed by: _______________________ Date: ____/______/ ______