ProCare Rx

JAI MEDICAL SYSTEMS

# Jai Medical Systems Managed Care Organization, Inc.
# Prior Authorization REQUEST FORM

**Fax Completed form to: ProCare Rx at 1-800-583-6010**

**QUESTIONS? Please call thePharmacy Services Department at 1-800-555-8513**

☐ ***Urgent*** (Please only check this box if applying the standard review time frame may seriously jeopardize the member's life, health, or ability to regain maximum function. Please provide explanation if box is checked.)

☐ ***Standard*** (Standard review timeframe is 2 business days for complete requests.)

**Member's Name:** _____
**First** **Middle I.** **Last**

**Member's ID Number:** _____ **Date of Birth:**_____/_____/_____

**Physician:** _____ **Contact Person at office:** _____

**Phone Number:** _____ **Fax Number:** _____

**Requested Medication:**_____**Medication Allergies:** _____

**Quantity:** _____ **Days Supply:** _____

**Relevant Diagnosis:** _____ **ICD Code:** _____

**Is this Therapy NEW** ☐ **or a CONTINUATION OF THERAPY** ☐ **Start date:** _____

**Previous Medication History:**

| Drug Strength and Dose | Dates of Therapy | Reason for Discontinuing |
|---|---|---|
| | | |
| | | |
| | | |

**Rationale for Request**

_____

_____

_____

_____

**Physician's Signature:**_____**Date:**____/____/_____

**In order to expedite processing please include lab reports with requests when appropriate, e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC; etc.**

*Revised 04/2016*