



EXPRESS SCRIPTS®
Charting the Future of Pharmacy

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Prior Authorization Request Form

FAX to ESI: 800-357-9577

Please Note:

If the following information is NOT filled in completely, correctly or legibly, the authorization review **will be delayed.**

Insurance Company _____

Patients Prescription ID# _____

Patient Full Name _____

Patient Date of Birth _____

Medication Requested _____

Quantity Requested _____ **for** _____ **days supply**

Physician Name (please print clearly) _____

Physician DEA number (required) _____

Physician Specialty _____

Physician Address _____

Physician Phone _____ **Physician Fax** _____

Diagnosis-Indication-Medical History (reason for use of this medication)

Other Medications/Therapies Tried and Reason(s) for Failure _____

Physician Signature _____ **Date** _____

Office Contact Person _____

Any further information pertaining to this drug request should be included and attached to this form.