ARCHIMEDES™

MEDICATION PREAUTHORIZATION REQUEST PHYSICIAN FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

PLEASE INCLUDE APPLICABLE CHART NOTES, LABORATORY RESULTS and RADIOLOGY FINDINGS

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration.

PATIENT INFORMATION **Today's Date:**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	

INSURANCE INFORMATION

Member ID Number:	Group Number:

PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician NPI#:	**Provider TIN:**	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

Patient's Diagnosis (ICD Code plus Description):	
Medication Requested:	Strength:
Dosing Schedule (Frequency):	Quantity per Month:
Route of Administration:	Expected Length of Therapy

1. Has the patient been on this medication in the past 6 months? Yes No Start date:_____
2. Has the patient tried and had an inadequate treatment response or intolerance to first line agents? Yes No
   Please list:_____
3. Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? Yes No
4. Has the patient had appropriate laboratory and/or genetic testing to support the diagnosis? Yes No
5. *Renewals only*: Has the patient improved while on this treatment? Yes No
6. Have chart notes been attached to this request? ***(Required)*** Yes No

Please fax or mail this form to:
Archimedes, LLC
5250 Virginia Way, Ste 300
Brentwood, TN 37027

TOLL FREE

Fax: 866-491-6971 Phone: 888-504-5563

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