MAXORplus®
PHARMACY BENEFIT MANAGEMENT SERVICES

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Phone: 800-687-0707 Fax back to: 844-370-6203

MaxorPlus manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescriber. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State ZIP: ,	City, State ZIP: ,
Primary Phone:	Specialty/facility name (if applicable):

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Drug Name: Expedited/Urgent ☐

Q1. Dosage and Directions for Use:
Q2. Quantity Requested:
Q3. Anticipated duration of therapy:
Q4. Prescription only PPIs (proton pump inhibitors), NSAs (non-sedating antihistamines), and nasal steroids are excluded from coverage unless there is a medical reason why the over-the-counter (OTC) equivalent cannot be prescribed. The OTCs are covered by the plan with a prescription. Is an alternative OTC acceptable? If so, PLEASE CONTACT PHARMACY WITH NEW RX. ☐ Yes ☐ No
Q5. Have multiple OTC alternatives been tried and either found not to be effective or did the patient experience an adverse event to the OTC alternatives? If so, please provide medical records confirming this to be the case and additional information below. ☐ Yes ☐ No
Q6. List the prior alternative OTC medications that have been tried previously:
Q7. Additional/Supporting Comments:

Prescriber Signature Date