

Parkway Medical, PLC  
6565 East Greenway Parkway, Suite 100  
Scottsdale, AZ 85254

PRIOR AUTHORIZATION REQUEST

The medication you have requested is not on your health plan formulary or is at a higher level of co-pay that you must assume. The method to get it approved depends on your health plan; however, certain information is needed in order to obtain authorization.

If you would like a medication that is not on your health plans approved list of medications, please fill in the information requested below. You can drop this form off at Parkway Medical for a signature and we will submit it to your health plan on your behalf.

Your name \_\_\_\_\_  
Health Plan name \_\_\_\_\_  
Your ID number \_\_\_\_\_  
Your Primary Care Doctor \_\_\_\_\_

Name of medication you are requesting \_\_\_\_\_

What is the reason you need a non-formulary medication?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List the medications you have tried and length of time you used each of them

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What problem have you had with the medication(s) you have tried in the past?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Print Your Name

\_\_\_\_\_  
Print Provider's Name

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date