LEADWAY Rx

Prior Authorization Form

Please make sure chart notes and all other clinical information are attached. To submit, please fax to (601) - 939-2380 or email to info@LeadwayRx.com. **PLEASE NOTE:** Chart notes are required for review.

Urgent	Non-Urgent	REASON FOR URGENCY
☐	☐	

Patient Information:

PATIENT NAME	DATE OF BIRTH (MM/DD/YYYY)	
ID NUMBER	SEX	HEIGHT
ALLERGIES		

Prescriber Information:

PRESCRIBER NAME	PHONE NUMBER (XXX) XXX-XXXX
PRESCRIBER SPECIALTY	FAX NUMBER (HIPAA COMPLIANT)
NPI NUMBER	OFFICE CONTACT

Medication Requested:

DRUG REQUESTED (INCLUDE STRENGTH & FORMULATION)

FULL DIRECTIONS FOR USE - (INCLUDE DOSING INSTRUCTIONS AND/OR LIMITS, FREQUENCY, AND SCHEDULE):

QUANTITY PER FILL	DIAGNOSIS AND ICD 10
DAYS SUPPLLY	EXPECTED LENGTH OF THERAPY

Type of Therapy:

☐ NEW THERAPY ☐ CONTINUATION OF THERAPY	DATE STARTED:

HAS THE MEMBER TAKEN THIS MEDICATION CONTINUOULLY SINCE THE ABOVE DATE? ☐ YES. ☐ NO

www.LeadwayRx.com

Phone: 888-878-7855 | **Fax**: 601-939-2380

Address: 219 Sunnybrook Rd Ste A Ridgeland, MS 39157

Medication History (For this Condition):

For all medications that have been tried and failed for this indication, please provide all of the following details for each medication. Incomplete documentation may result in the delay in approval or denial.

- Medication product and dose(s) used
- Start date - End date of medication trial (or start date – current, if still taking)
- Reason for failure (explaining why the medication was/is considered failed therapy)
    - If failed due to intolerance, provide details & description of intolerance.

Medication Tried Medication product & Dose(s) used	**Date & Duration of Trial** Start Date - End Date	**Reason for Failure or Intolerance** Details & Description

Other Pertinent Information:

Please provide any other pertinent medical history, relevant lab values, or concurrent medications, not previously stated anywhere else on this Prior Authorization Form. For any preferred medication therapies that are not possible to use, please give rationale for the clinical reasoning behind that decision.

Additional Documentation:

Please provide the following documentation with submission:

- Chart notes for this diagnosis, including the most recent assessment and treatment plan
- Hospital discharge summary (if applicable)
- Results from previous procedures and/or tests
- Any information/documentation that is not listed anywhere else on the form, that you believe to be pertinent to the review of this prior authorization

PRESCRIBER SIGNATURE	DATE

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