COVERAGE DETERMINATION REQUEST FORM

Slate Rx

Prior Authorization Request

Phone: 833-320-1824 Fax back to: 866-351-1617

SlateRx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions, sign 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:	

☐ Standard ☐ Expedited / Urgent

Drug Name and Strength:

Directions / SIG:

Q1. Please indicate the patient's diagnosis the requested medication is treating.

Q2. Is the request for initial or continuing therapy? (If continuation of therapy, please include the start date - MM/YYYY)

☐ Initial therapy ☐ Continuing therapy _____

Q3. Please list all other medications the patient has previously tried for the indicated diagnosis along with the dates and outcomes (e.g., ineffective, adverse reaction, etc.):

Q4. Please provide any supporting clinical statements such as medical records, chart notes, lab values, contraindications, or any other additional clinical information to support the request for coverage.

Prescriber Signature: _____ Date: _____