



1650 Spring Gate Lane  
 Las Vegas, NV 89134  
 Tel: 888-869-4600

Please Note: Medical Necessity Prior Authorization may be utilized to override both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

## PRIOR AUTHORIZATION FORM

COMPLETE AND FAX TO CATALYST Rx AT 888-852-1832

MEMBER INFORMATION			
First Name		Last Name	
Plan			
Member ID		Date of Birth	
DRUG INFORMATION			
Drug Name			
Quantity		ICD-9	
Directions		Duration of Therapy	
Diagnosis			
PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.			
Medication/Failure Reason:			
ESR: _____ CRP: _____ # Joints: _____ %BSA: _____			
Height: _____ Weight: _____ BMI: _____			
HA1C: _____ Hemoglobin: _____ Hematocrit: _____ T-Score: _____			
Dialysis: _____ Long Term Care Facility: _____ Self Injecting: _____			
Stimulation test: _____ / _____ Growth velocity: _____ #Chemotherapy cycles/month: _____			
Mini-Mental Status Test: _____ Baseline Free testosterone/Total testosterone: _____ / _____			
HCV RNA viral load: _____ Viral Genotype: _____ ALT: _____			
PHYSICIAN INFORMATION			
Physician Signature		Date	
Physician Name		NPI #	
Phone Number		Fax Number	
Action Needed	Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function  <input type="checkbox"/> Urgent <input type="checkbox"/> For Review	Pharmacy Fax	

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