Prior Authorization Form

Please submit one drug per form.

Questions? Contact us:
Phone: (844) 512-3030
Fax: (866) 642-5620

SmileRx

Prescribing Physician

Prescriber Name

Physician Specialty

NPI Number

DEA Number

Phone Number

Fax Number

Requestor Name

Office Contact Name

Patient Information

Last Name

First Name

M.I.

ID Number

Date of Birth (MM/DD/YYYY)

Sex M F

Allergies

Height (in/cm)

Weight (lb/kg)

Requested Drug Details

Drug Name | **Strength** | **Dosage Form** | **Length or Therapy / # of Refills** | **Quantity**

Directions for use:

Patient's diagnosis for use of this medication

ICD 9/10

Select one of the following (circle one):

New Prescription

Continuation of Therapy, Start Date:_____

Previous Medications

Please list all previous medications tried and failed for this condition:

Name of Medication	Reason for Failure or Inability to Use	Date Range Tried

Prescriber Signature (required):

Date:

This form MUST be returned along with recent chart / consultation notes and all relevant labs.

Thank you for your time. We'll process your request as soon as it is received.