PreferredOne®

Medication Request Form

Attn: Pharmacy Dept. Fax (763.847.4014) **All fields required. Incomplete and/or Incorrect forms will be returned.**

Please follow-up with PreferredOne Customer Service (800.997.1750 Option #3) for Approval/Denial status of this request.

MEMBER INFORMATION

MEMBER NAME:			
MEMBER ID:	DATE OF BIRTH:		GENDER: ☐ M ☐ F ☐ O
ADDRESS:	CITY:	STATE:	ZIP:

PROVIDER INFORMATION

PROVIDER NAME: *(FIRST & LAST)*	NPI NUMBER:	SPECIALTY:
CLINIC NAME:	CONTACT: *(NAME & PHONE)*	SECURE FAX/EMAIL:

ADDRESS:	CITY:	STATE:	ZIP:
PHARMACY NAME:	PHARMACY PHONE:	PHARMACY FAX:	

REASON FOR REQUEST (SELECT ALL THAT APPLY)

☐ PRIOR AUTHORIZATION ☐ NON-FORMULARY ☐ LARGER QUANTITY: (QUANITY REQUESTED)

☐ OFFICE INJECTION/INFUSION: Please use the Infusion Authorization Form located on PreferredOne.com under Provider Forms.

MEDICATION REQUESTED

DRUG NAME AND STRENGTH:	DIAGNOSIS (ICD-10):
DIRECTIONS:	

IS THE PATIENT CURRENTLY BEING TREATED WITH REQUESTED DRUG? ☐ YES ☐ NO
IF YES, PLEASE INDICATE DATE TREATMENT BEGAN:

PLEASE LIST ALL OTHER MEDICATIONS THE PATIENT WILL BE TAKING IN **COMBINATION** WITH THE REQUESTED MEDICATION FOR **THIS DIAGNOSIS**:

MEDICATIONS TRIED AND FAILED FOR THIS DIAGNOSIS: PLEASE COMPLETE ALL FIELDS

DRUG NAME AND STRENGTH:	DIRECTIONS:	DATES:
ADVERSE REACTION TO OR FAILURE OF ALTERNATIVE: ☐ YES ☐ NO IF YES, LIST REACTION OR FAILURE:		
DRUG NAME AND STRENGTH:	DIRECTIONS:	DATES:
ADVERSE REACTION TO OR FAILURE OF ALTERNATIVE: ☐ YES ☐ NO IF YES, LIST REACTION OR FAILURE:		
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ADVERSE REACTION TO OR FAILURE OF ALTERNATIVE: ☐ YES ☐ NO IF YES, LIST REACTION OR FAILURE:		

Please note that this, and other PreferredOne prescription prior authorization requests, can be completed online at **PreferredOne.com/providers**. For assistance locating these forms, please reach out to PreferredOne Customer Service at 800.997.1750 Option #3.