ARKANSAS
PRESCRIPTION DRUG PRIOR AUTHORIZATION FORM

Attn: *Navitus Health Solutions*
PO BOX 999
Appleton, WI 54912-0999
Phone: (866) 333-2757
Fax: (855) 668-8551

This form is being used for:		
Check one:	☐ Initial Request	☐ Continuation of Therapy/Renewal Request
Reason for request *(check all that apply)*:	☐ Prior Authorization, Step Therapy, Formulary Exception ☐ Quantity Exception ☐ Specialty Drug ☐ Other *(please specify)*: _____	
☐ **By checking this box, I attest this is an urgent case, meaning that an expedited determination is necessary to prevent serious threat to life, limb, or eyesight; or threatens the body's ability to regain maximum function; or is needed to manage severe pain.**		

Patient Information		
Patient Name:	DOB:	Gender: ☐ Male ☐ Female ☐ Unknown
Member ID #:		

Prescriber Information		
Prescribing Clinician:	Phone #:	
Specialty:	Secure Fax #:	
NPI #:	DEA/xDEA:	
Prescriber Point of Contact Name (POC) (if different than provider):		
POC Phone #:	POC Secure Fax #:	
POC Email (not required):		
Prescribing Clinician or Authorized Representative Signature:		
Print Authorized Representative's Name:		Date:

Medication Information	
Medication Being Requested:	
Strength:	Quantity:
Dosing Schedule:	Length of Therapy:
Date Therapy Initiated:	
Is the patient currently being treated with the drug requested? ☐ Yes ☐ No If yes, date started:	
If renewal, has the patient shown improvement in related condition while on therapy? ☐ Yes ☐ No ☐ N/A	
If yes, please describe:	
Dispense as Written (DAW) Specified? ☐ Yes ☐ No	
Rationale for DAW:	

Compound and/or Off Label Use	
Is Medication a Compound? ☐ Yes ☐ No	
If Medication Is a Compound, List Ingredients:	
For Compound or Off Label Use, include citation to peer reviewed literature:	

Patient Clinical Information	
Primary Diagnosis Related to Medication Request:	
ICD Codes:	
Pertinent Comorbidities:	
Drug Allergies:	
Height:	Weight:
Pertinent Concurrent Medications:	
Opioid Management Tools in Place: ☐ Risk assessment ☐ Treatment Plan ☐ Informed Consent ☐ Pain Contract ☐ Pharmacy/Prescriber	
Previous Therapies Tried/Failed:	

Previous Therapies Tried and/or Failed

Drug Name	Strength	Dosing Schedule	Date Prescribed	Date Stopped	Description of Adverse Reaction or Failure	Check if Sample
						☐
						☐
						☐
						☐
						☐

Are there contraindications to alternative therapies? ☐ Yes ☐ No
If yes, please list details:
Were nonpharmacologic therapies tried? ☐ Yes ☐ No
If yes, provide details:

Relevant Lab Values

Lab Name and Lab Value	Date Performed	Lab Name and Lab Value	Date Performed

Additional information pertinent to this request:

Fax completed form to Navitus Health Solutions at 855-668-8551