



Date: ____/____/____

Patient Name: _____

ID#: _____ DOB: ____/____/____

Diagnosis: _____

Medication Requested: _____

Dosage & Regimen Prescribed: _____ Anticipated Duration*: _____

*Maximum duration for approvals is one year, and may be less for acute care or at Plan discretion.

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HNNY USE

Justification for Request: (Where applicable, please list other medications, allergies or therapeutic measures attempted and results; additional supporting documentation such as lab reports and test results should also be attached):

Medications Tried

_____	_____
_____	_____
_____	_____
_____	_____

Prescribing Physician Name (Please Print): _____

Prescribing Physician Signature: _____

DEA # _____

Provider # _____

Telephone # (____) _____

FAX # (____) _____

HNNY USE ONLY

Pended (Information Needed to Complete Request (Our Decision Is Pending Your Response)):
DATE PENDED REQUEST WILL BE CLOSED: ____/____/____

Date: ____/____/____ Signature: _____

Determination: Denied Approved **Time Period:** _____

Reason:

Date: ____/____/____ Signature: _____

Approvals are only valid if person has active prescription drug coverage through HealthNow New York. This prior authorization is subject to all drug therapy guidelines in effect at the time of the approval and other terms, limitations and provisions in the member's contract/rider. We reserve the right to update and/or modify our drug therapy guidelines for prospective services.