

Has the member tried other medications to treat this condition? <input type="checkbox"/> Yes. Provide this information in the area to the right. You may be asked to provide supporting documentation such as copies of medical records, office notes or complete FDA MedWatch form. <input type="checkbox"/> No. Explain why not: _____ _____ _____ _____	Drug(s) name and strength	
	Date range of use	SIG (dose and frequency)
	Did member experience any of the below? <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Other Briefly describe details of adverse reaction, inadequate response or other in the space provided below: _____ _____ _____	

Describe medical necessity for nonpreferred medication(s) or for prescribing outside of FDA labeling:

List all current medications, including dose and frequency:

Other pertinent information:

Diagnostic studies and/or laboratory tests performed
 List all tests done within the past 30 days that are related to diagnosis for medication requested.

Labs:			Diagnostic tests:		
Test	Date	Result	Procedure	Date	Result

Prescriber signature (REQUIRED): _____

Date: _____

(By signature, the prescriber confirms the above information is accurate and verifiable by patient records and understands that any falsification, omission or concealment of material may be subject to civil or criminal liability.)

Fax this form to 1-844-490-4876.
For telephone PA requests or questions, please call 1-844-396-2330.
Please allow Anthem at least 24 hours to review this request.