

## Request for Prior Authorization- Medical Injectables

Dean Health Plan is your partner in providing care.  
In order to efficiently process your authorization request, the information below must be completed.

<b>Member Information:</b> *Full Name: _____ Address: _____ Telephone #: (____) _____ *DOB: ____/____/____ Primary Insurance Name (COB): _____ Primary Insurance ID and effective date #: _____ Member height _____ Member weight _____	
Requested Diagnosis Code: _____ _____ Requested J, S or Q Code: _____ Drug Name and strength: _____ Directions _____ Requested Number of Units: _____ DOS From: ____/____/____ to ____/____/____	
<b>PLEASE SEND CLINICAL NOTES AND ALL SUPPORTING DOCUMENTATION</b>	
<b>Requesting Provider:</b> Name: _____ NPI #: _____ TIN#: _____ AHCCCS ID: _____ Telephone #: _____ Address: _____ Fax #: _____ Contact Name/Phone #: _____	<b>Servicing Provider/Facility:</b> Name: _____ NPI #: _____ TIN#: _____ AHCCCS ID: _____ Telephone #: _____ Address: _____ Fax #: _____ Contact Name/Phone #: _____

Submitted By: \_\_\_\_\_ (Please Print) Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Please Print)

**\*Please submit all supporting documentation and any applicable information with this request form\***

**Pharmacy Department Phone: 608-828-6393**  
**Pharmacy Department Fax: 608-252-0814**



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