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GatorCare
Your Partner in Health

Prescription Drug
Prior Authorization Request Form

MEMBER INFORMATION

LAST NAME:

FIRST NAME:

MEMBER ID NUMBER:

WEIGHT (CHECK ONE UNIT OF MEASUREMENT):

☐ kg **OR** ☐ lbs

DATE OF BIRTH:

– –

PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

NPI NUMBER:

PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM:

PHONE NUMBER:

– –

FAX NUMBER:

– –

PHARMACY INFORMATION (IF AVAILABLE)

PHARMACY PROVIDER

PHARMACY'S PHONE NUMBER:

– –

PHARMACY'S FAX NUMBER:

– –

Drug Name	Strength	Directions for Use	Diagnosis

PREVIOUS MEDICATIONS (PLEASE INCLUDE DATES AND OUTCOME) **AND OTHER MEDICAL JUSTIFICATION FOR USE:**

Prescriber's Signature (Required) **Date** **Prescriber Specialty**

Fax this request to: 1-888-272-1349

Questions? Please call **1-800-651-8921** or visit us at: https://gatorcare.magellanrx.com/