

Express Scripts, Inc.
Prior Authorization Request Form
Fax (877) 837-5922

Phone (800) 417-8164

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information. Our standard response time for prescription drug coverage requests is 2 business days. View our formulary online at <http://www.scanhealthplan.com>.

Please Note: If the following information is NOT filled in completely, correctly or legibly, the authorization review **will be delayed.**

Insurance Company SCAN®

Patients ID# _____

Patient Full Name _____

Patient Date of Birth _____

Medication Requested _____

Quantity Requested _____ **for** _____ **days supply**

Physician Name (please print clearly) _____

Physician DEA number (required) _____

Physician Address _____

Physician Phone _____

Physician Fax _____

Diagnosis-Indication-Medical History (reason for use of this medication)

Other Medications/Therapies Tried and Reason(s) for Failure _____

Physician Signature _____ **Date** _____

Office Contact Person _____

Any further information pertaining to this drug request should be included and attached to this form.