Banner University Health Plans

Pharmacy Prior Authorization Request Form

Note: To ensure that prior authorizations are reviewed promptly, submit request with current clinical notes and relevant lab work.

Fax completed form to:
(866) 349-0338

Date: _____ **Request Type:** ❑ **Standard** ❑ **Expedited**

HEALTH PLAN

❑ **Banner – University Family Care (ACC)**
❑ **University Care Advantage (Medicare HMO SNP)**
❑ **Banner – University Family Care (ALTCS)**

MEMBER INFORMATION

Name: Last	First	MI
Date of Birth:	**Member ID#:**	**Phone:**

REQUESTING PROVIDER INFORMATION

First & Last Name:	**NPI:**
Phone:	**Fax:**

MEDICAL INFORMATION / MEDICATION REQUEST

Medication:	**Quantity:**	**Dosing Regimen:**	**Duration of Therapy:**
Relevant Diagnoses:			
Reason for Exception:			
Alternative Medication(s) Tried & Reason(s) for Failure:			

For Office Use Only:

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SAVE FORM

RESET FORM