



Today's date: _____

Date medication needed: _____

Prior Authorization Form Direct Ship General Drug Request – Medical Benefit Drugs Only

IF YOU ARE ORDERING BOTULINUM TOXINS (BOTOX, DYSPORT, MYOBLOC, XEOMIN), PROLIA/XGEVA, STELARA, SYNAGIS, XOLAIR, OR MAKENA/17 ALPHA-HYDROXYPROGESTERONE CAPROATE, PLEASE DOWNLOAD THE APPROPRIATE DRUG-SPECIFIC FORM AT: www.ibx.com/directship.

USE THIS FORM TO REQUEST ALL OTHER DRUGS AVAILABLE THROUGH THE DIRECT SHIP DRUG PROGRAM. THE COMPLETE LIST OF ALL DRUGS AVAILABLE THROUGH THIS PROGRAM IS AVAILABLE AT: www.ibx.com/pdfs/providers/pharmacy_information/direct_ship/direct-ship-injectables-list.pdf.

REQUESTS FOR DRUGS THAT ARE NOT ON THE DIRECT SHIP DRUG LIST (SEE ABOVE) WILL NOT BE PROCESSED.

ONLY COMPLETED REQUESTS WILL BE REVIEWED.

Drug being requested: _____ Check one: New start Continued treatment

Patient information (please print)

Physician information (please print)

Patient name			Prescribing physician	
Address			Office address	
City, state, ZIP			City, state, ZIP	
Patient telephone #			Office contact	
Patient ID			Office telephone #	
Date of Birth	Weight	Height	Fax #	NPI

No delivery requested; physician will use office supply. Authorization only.

Delivery requested to the physician's office.

** A copy of the prescription must accompany the medication request for delivery.**

1) Physician specialty (specify all): _____

2) Diagnosis for drug requested (must include ICD-10): _____

3) Supporting member medical information/history

Please add any member information that may be useful in the decision-making process.

4) Prescription Information:

Quantity _____ | Refill x _____ month(s)

Instructions (include dose) _____ every _____ day(s)/ week(s)/ month(s)

Physician's Signature: _____

Please fax this completed form to 215-761-9580.

10/01/2015