ORANGE PLAZA PHARMACY

Prior authorization Request

MEDICATION NAME AND STRENGTH: _____

PATIENT NAME _____ PRESCRIBER NAME _____

DATE OF BIRTH _____ MD SPECIALTY _____

PHONE # _____ MD ADDRESS_____

ADDRESS _____ _____

_____ PHONE # _____

INSURANCE _____ FAX# _____

PLEASE ATTACH THE FOLLOW TO COMPLETE AUTHORIZATION

- ☐ PRESCRIPTION
- ☐ DIAGNOSIS, PROGRESS NOTES, LABS

The following prescription requires a prior authorization from the insurance company. By signing below, the prescriber gives consent to **Orange Plaza Pharmacy to act as the prescriber's agent** to begin and execute the prior authorization process, as well as to help the patient apply to co-pay assistant programs (including coupons, foundations and manufacturer assistance programs if necessary). If you wish to complete the authorization at the prescriber's office, please advise Orange Plaza Pharmacy.

PRESBRIBER SIGNATURE: _____ DATE: _____