REQUEST FOR PRESCRIPTION DRUG PRIOR AUTHORIZATIONS FOR PRESCRIBERS

This form must be filled out electronically and emailed to: Email Address: NHIClinical@vinhi.vg

Enrollee's Information

Enrollee's Name		Date of Birth
Enrollee's Address		
City	State	Zip Code
Phone	Enrollee's Member ID #	

Name of prescription drug you are requesting (if known, include strength and quantity requested per month):

Type of Prior Authorization Request

☐ My patient needs a drug that is not on the NHI's list of covered drugs (formulary).

☐ My patient needs an exception to the prior authorization requirements (please fill out additional information below)

Supporting Information for Prior Authorization

Prescriber's Information		
Name		
Address		
City	State	Zip Code
Office Phone	Fax	
Prescriber's Signature		Date

Diagnosis and Medical Information			
Medication:	Strength and Route of Administration:		Frequency:
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:		Quantity:
Height/Weight:	Drug Allergies:	Diagnosis:	

Rationale for Request

Required Explanation _____

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Signature:	**Date:**

Save **Print** **Submit**