



1650 Spring Gate Lane
Las Vegas, NV 89134
Tel: 1-877-634-9202

Plavix Prior Authorization Form

(To be completed by a healthcare professional only.)

COMPLETE AND FAX TO CATALYST Rx AT 1-888-852-1832

PHYSICIAN INFORMATION			
Name of person completing this form		Date Faxed	
Physician Name		Physician Specialty	
Phone Number		Fax Number	
NPI or DEA #		Pharmacy Fax	
MEMBER INFORMATION			
First Name		Last Name	
Plan	TOTAL HEALTH CARE		
Member ID		Date of Birth	
DRUG INFORMATION			
Drug Name		Drug Strength	
Quantity		Duration of Therapy	
Directions			
Diagnosis			
<p><i>Please indicate reason for therapy</i> <i>You must provide the date where applicable</i></p> <div style="border: 1px solid black; padding: 10px; margin: 10px auto; width: 80%;"> <ul style="list-style-type: none"> <input type="checkbox"/> Unstable angina <input type="checkbox"/> Brachytherapy <input type="checkbox"/> Acute coronary syndrome(NSTEMI or STEMI) <input type="checkbox"/> Documented aspirin allergy (anaphylaxis, bronchospasm) <input type="checkbox"/> Cerebrovascular disease with recurrent ischemia <input type="checkbox"/> Coronary Artery Bypass Graft (CABG) (Date of CABG_____) <input type="checkbox"/> Peripheral stent (renal, inguinal, popliteal) (Date of stent_____) <input type="checkbox"/> Post PCI/stent placement (Date of stent_____) <input type="checkbox"/> Intracranial stent (Date of stent_____) <input type="checkbox"/> Carotid stent (Date of stent_____) <input type="checkbox"/> Other_____ </div>			

Only mark urgent when standard review time would seriously harm the member's life, health or ability to function URGENT FOR REVIEW

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