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

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			

ALL FIELDS MUST BE COMPLETE FOR PRIOR AUTHORIZATION REVIEW.

Has this patient tried other medications for this condition? *(List drug and duration, provide chart notes to support)*

Clinical rationale for selected drug usage:

Pertinent Laboratory Tests or Procedures and Results: *(If not present, within normal limits will be used for the review.)*

Is patient currently taking this medication? ________ If so, how long? ______ Were Samples given? ________

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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