UNIVERSITY OF COLORADO HOSPITAL
MEDICATION MANAGEMENT SERVICES
CU-ANTHEM PRIOR AUTHORIZATION REQUEST FORM

DATE:	PRIORITY (circle one): ROUTINE URGENT
PATIENT NAME:	PHYSICIAN'S NAME:
MEDICAL RECORD #:	SPECIALTY:
DATE OF BIRTH:	PHYSICIAN'S PHONE# ( )
POLICY ID #:	PHYSICIAN'S FAX# ( )
PATIENT PHONE #	PHYSICIAN'S PAGER# ( )

MEDICATION REQUESTED (including strength and dose):

DIAGNOSIS:

MEDICATION ALLERGIES:

REASON FOR REQUEST: (please attach additional information such as progress notes and supporting references):

ANTICIPATED TREATMENT DURATION:

OTHER PERTINENT INFORMATION: (include lab results if appropriate, previously failed therapies)

PHYSICIAN'S SIGNATURE:

Office Use Only

Approved by:	Date:
Approval # :	
Effective Dates:	
Denied by:	Date:

Fax this form to (720) 848-1475
or scan and email to pharmacy@uch.edu