Prior Authorization Form

EFFIENT®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: *(check one)* ☐ **Effient®** ☐ **Other (specify)** ____________________

Date: ____________________ Patient ID#: ______________ DOB: __________

Patient Name: ____________________ Provider NPI: ____________________

Prescribing Physician: ____________________ Office Contact: ____________________

Office Fax #: ____________________ Office Phone: ____________________

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. DIAGNOSIS FOR DRUG REQUESTED:

☐ Acute Coronary Syndrome (ACS)
☐ Other (specify)____________________

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

☐ **N/A** If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration

3. PATIENT HISTORY:

a. Is the patient managed with Percutaneous Coronary Intervention (PCI)? ☐ Yes ☐ No

Please add any other supporting medical information that may be useful in the decision-making process:

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FAX: (888) 671-5285 or EMAIL: FSS_Standard_Medicare@catalystrx.com
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL

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