

3 SIMPLE WAYS TO SUBMIT A Prior Authorization Request

Electronic Prior Authorization (ePA)

★ PREFERRED • FASTEST



Submit instantly through SureScripts at sso.surescripts.net/account/login

New to ePA? Visit verus-rx.com for quick registration steps.

Online PA Webform



Submit your request online
in minutes at paforms.com/verusrx

Fax This Form



Fax the completed form to
our PA team at **833-225-1973**

PRESCRIBER

One or more of your patient's prescriptions requires a prior authorization (PA). Please use one of the submission options above — ePA is the fastest way. You will receive a response to each PA request submitted.

PATIENT NAME

DATE OF BIRTH

MEDICATION(S)

RENEWALS ONLY — CURRENT PA EXPIRES ON

Questions about this form or a submission? Call **405-267-7574** (physicians and pharmacies only).

Prior Authorization (PA) Request Form

Prescription Drug | Prior Authorization Department 405-267-7574 | VerusRx Toll-Free 1-800-838-0007

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation (e.g., chart notes or lab data) that supports this request.

☐ **Check if URGENT:** The prescriber attests that applying the standard timeframe could seriously jeopardize the member's life, health, or safety.

PATIENT INFORMATION — required in full for HIPAA compliance

First Name		Last Name		MI		Phone Number	
Address			City		State		Zip Code
Date of Birth		☐ Male ☐ Female	Height (in)		Weight (lbs)		Allergies
Authorized Representative (if applicable)				Rep. Phone Number			

INSURANCE INFORMATION

Primary Insurance Name		Patient ID Number	
Secondary Insurance Name		Patient ID Number	

PRESCRIBER INFORMATION

First Name		Last Name		Specialty	
Address			City		State
Requester (if different than prescriber)			Office Contact Person		
NPI Number			Phone Number		
DEA Number			Fax Number (HIPAA-compliant line)		
E-mail Address					

MEDICATION & DISPENSING INFORMATION

Medication Name					
☐ Dispense as written ☐ Generic substitution permitted If neither is selected, this request will be reviewed as "generic substitution permitted."					
☐ New Therapy	☐ Renewal	Date Therapy Initiated		Duration of Therapy	
Pharmacy Name					
Pharmacy Phone		Pharmacy Fax			
Dose/Strength		Frequency		Refills	
Quantity					
Route of Administration:	☐ Oral/SL	☐ Topical	☐ Injection	☐ IV	☐ Other
Administration Location:	☐ Patient's Home	☐ Long Term Care	☐ Physician's Office		
	☐ Home Care Agency	☐ Ambulatory Infusion	☐ Outpatient Hospital	☐ Other	

PATIENT NAME

ID#

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation (e.g., chart notes or lab data) that supports this request.

1. HAS THE PATIENT TRIED OTHER MEDICATIONS FOR THIS CONDITION?☐ Yes ☐ No

Medication / Therapy

Duration of Therapy

Response / Reason for Failure or Allergy

2. REQUIRED CLINICAL INFORMATION

Diagnosis Description

ICD-10 Code

Provide symptoms, lab results with dates, and/or justification for therapy, including any contraindications to the preferred drug.

Current Medication List

☐ Additional documentation attached

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of this request.

Prescriber Signature

Date

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, any disclosure, copying, distribution, or action taken on the contents is strictly prohibited — please notify the sender by return fax and arrange for the return or destruction of these documents.

Electronic PA (ePA)

Available through SureScripts at
sso.surescripts.net/account/login

Online PA Webform

Submit online at
paforms.com/verusrx

Fax This Form

Fax the completed form to our
PA team at **833-225-1973**