# Prior Authorization Request

MIA/ Homeless Program

Member Name:
Member MRN:
Member DOB:
Provider Name:

| | |
|---|---|
| Medication | |
| Strength | |
| Directions | |
| Diagnosis (ICD9) | |
| Previous formulary medications used and length of therapy | |
| What was outcome of previous therapies (eg. Adverse reaction) | |
| Justification: why do you think this medication will work better than formulary medications? | |
| Lab work to support request (LDL, HDL) | |
| Goal of Therapy | |
| Length of therapy | |