

Bravo Health

Coverage Review / Prior Authorization Request Form



Quantity Limits

Patient Information		Prescriber Information	
Member Name:		Prescriber Name:	
Bravo ID #		Prescriber Specialty:	
DOB:		Prescriber Address:	
Address:			
		Office Phone#:	
Home Phone:		Office Fax #:	
		Contact Person:	

Diagnosis and Medication Requested

Medication Requested (dosage, frequency):		Qty/days supply:	
Prescribing Diagnosis:	ICD9 Code	Date Therapy Initiated:	

Clinical Criteria

Please answer the following question:

1. Is a greater drug quantity necessary to achieve the prescribed dose?

Yes* (see note below) No

*** If dose exceeds recommended daily maximum, please provide clinical evidence to support the use of this medication at the specific requested dose for the treatment. Clinical evidence must be documented by large-scale, double-blinded, placebo-controlled clinical trials or widely accepted clinical guidelines published in nationally recognized, peer-reviewed medical journals.**

Additional Comments/Explanation:

Request for Expedited Review

REQUEST FOR EXPEDITED REVIEW [24 HOURS]

BY CHECKING THIS BOX AND SIGNING BELOW, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Prescriber's Signature:

Date: _____

Fax back to: 866-464-0709

For info call: 877-813-5595

For additional Prior Authorization forms, go to <http://www.bravohealth.com/providers.aspx>