

Ticket #: _____ Request Date: _____ Request Time: _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of **Hepatitis B Vaccine**. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information			
Patient Name:		Plan Name/Plan ID:	
Patient ID:		Patient Date of Birth:	Patient Contact Phone #:
B. Physician Information			
Physician Name:		Physician Address:	
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:
C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:
D. Clinical Information (Please fill out the following information)			
<p>Initial PA Request, please check all that apply directly to the patient:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Client of institutions for individuals for the mentally handicapped <input type="checkbox"/> End Stage Renal Disease (ESRD) <input type="checkbox"/> Hemophilia, received Factor VIII or IX concentrates <input type="checkbox"/> Homosexual male <input type="checkbox"/> Illicit injectable drug user <input type="checkbox"/> Patient lives in the same household as a hepatitis B virus (HBV) carrier <input type="checkbox"/> Patient is employed in institutions for the mentally handicapped <input type="checkbox"/> Patient is a health care professional who has frequent contact with blood or blood-derived body fluids during routine work <input type="checkbox"/> Other: _____ <p style="text-align: center;">PLEASE PROVIDE SUPPORTING CHART DOCUMENTATION</p>			
Authorized Medical Signature:			
Telephone:		Date:	

When Completed Return To:

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
 1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.

Prior authorization forms are reviewed at least annually and are available at www.MC-Rx.com. Medical Review Criteria are reviewed at least annually. Revised 5/2019