PARAMOUNT
INSURANCE COMPANY

Paramount Commercial / Employer-based insurance

Non-Specialty Drug Prior Authorization or Step Therapy Override Request

PHARMACY FAX # 844-256-2025

- Pertinent office notes and past medical history must be submitted with the prior authorization request.
- Use this form if specific criteria are not posted for the medication being requested.

PATIENT INFORMATION

Patient Name		Date
Paramount ID	DOB	Gender: M/F
Medication Allergies		

PROVIDER INFORMATION

Prescriber Name	NPI #	DEA #
Prescriber Specialty	Prescriber Address	
Office Fax	Phone	Office Contact Name

MEDICATION REQUESTED

Drug Name	Strength	Directions (Sig)
Duration of Therapy: Days:_____Months: _____	Quantity	**Diagnosis**
Is the Patient currently being treated with this medication? ☐ Yes; Date started mm/dd/yy__/____/_____ ☐ No		

MEDICAL JUSTIFICATION: Include Other Relevant Medications Tried and Results

Please indicate previous treatment and outcomes below					
Previous Medication	Strength	Qty	Directions (Sig)	Dates (mmddyy to mmddyy)	Reason for Discontinuation
1					
2					
3					
4					

RELEVANT MEDICAL RATIONALE FOR REQUEST/ADDITIONAL CLINICAL INFORMATION (Attach Relevant Lab Results and Chart Notes)*

In order to process this request, please complete all boxes completely.

Provider Signature	Date