



MEDTIPSTER.COM, LLC
REQUEST FOR PRIOR AUTHORIZATION
(ALL AUTHORIZATIONS ARE PENDING VALID ELIGIBILITY)

Prescribing Physician		Patient Information	
First & Last Name		First & Last Name	
Direct Phone #		Subscriber ID#	
Secure Fax#		Date of Birth	
Physician Specialty		Sex	☐ Female ☐ Male

Name and title of person completing form (please print): _____

****Please complete drug information below in its entirety. Prior authorization cannot be processed with missing information****

Drug Name	Strength	Administration Schedule	Length of Therapy	Quantity Requested:

Patient's diagnosis for use of this medication: _____

Previous history of medical condition, allergies, or other pertinent medical information that necessitates the use of this medication:

Has the patient been seen by any other provider for this condition? ☐ YES ☐ NO

If so, what was the prescriber's specialty? _____

Previous non-prior authorized and prior authorized medications tried and failed for this condition:

Name of Medication:	Reason for Failure:	Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pertinent laboratory test or procedures (if applicable):

****GLP-1 agonists must include recent A1c level within the last 6 months. Provide A1c levels below*****

Procedure/Lab Results:	Findings:	Date:
_____	_____	_____
_____	_____	_____

Other relevant information: ***For GLP-1 agonists, must include office visit notes***

Submit requests to:
Medtipster.com, LLC
Email: priorauth@medtipster.com
Phone: (877) 207 – 5939
Fax: (248) 502 – 3167

Office Use Only: ☐ New ☐ Renewal _____
First request: _____ Second request: _____
Group name/ID: _____
Location: _____ Person Code: _____
Rejection Code/s: _____