JAI MEDICAL SYSTEMS

ProCare Rx

Jai Medical Systems Managed Care Organization, Inc.
Prior Authorization Request Form

Please fax completed form and supporting clinical documentation to ProCare Rx at 1-866-999-7736 or 1-800-583-6010.
For any questions, please contact our Pharmacy Services Department at 1-800-555-8513.

☐ ***Standard*** (Standard review timeframe is **within 24 hours** for complete requests.)

☐ ***Urgent*** (Please only check this box if applying the standard review timeframe may seriously jeopardize the member's life, health, or ability to regain maximum function. Please provide an explanation if the box is checked.)

Member's Name: _____
First **Middle I.** **Last**

Member's ID Number: _____ **Date of Birth:** ____/____/____

Physician: _____ **Contact Person at Office:** _____

Phone Number: _____ **Fax Number:** _____

Requested Medication: _____ **Medication Allergies:** _____

Quantity: _____ **Days Supply:** _____

Relevant Diagnosis: _____ **ICD Code:** _____

Is this Therapy NEW ☐ **or a CONTINUATION of Therapy** ☐ **Start Date:** _____

Previous Medication History: Drug Strength and Dose	**Dates of Therapy**	**Reason for Discontinuing**

☐ Please check box if you are requesting an exception to the 14 day opioid quantity limit due to ongoing therapy.

Rationale for Request

_____

_____

_____

Physician's Signature: _____ **Date:** ____/____/____

BEFORE SUBMISSION: Please ensure that this form is completed in its entirety and that all supporting clinical documentation, such as lab reports when appropriate, are included. Incomplete forms cannot be accepted or processed, and will be returned to the requesting provider for completion. Please note, the rationale for a request must be completed detailing the supporting medical necessity for the request.

Revised 07/2023