1199SEIU Benefit and Pension Funds

National Benefit Fund (646) 473-9200 | Pension Fund • (646) 473-8666
Greater New York Benefit Fund • (212) 541-9150 | Pension Fund • (646) 473-8666
Home Care Employees Benefit and Pension Funds • (646) 473-9200
Home Health Aide Benefit Fund • (646) 473-7470

330 WEST 42ND STREET ■ NEW YORK, NY 10036-6977 ■ www.1199SEIUBenefits.org

Care Management Programs Department
Prescription Request for Authorization

1199SEIU Member's Name: ____________________________

Member ID: | | | | | | | | | | |

Patient (if not member): ______________________ Patient date of birth: _____ / _____ / _____ Age: ________

♦♦

Check the appropriate prescription

Drug Class	Document Drug Name/Dosage/Duration
☐ **ORAL**	
☐ CNS Stimulants (**Required document - Psychological evaluation)**	______________________
______________________	______________________
☐ Other	______________________
	______________________
☐ **TOPICAL**	
☐ Acne products	______________________
	______________________
☐ Testosterone replacement product (**Required document – Lab test results)**	______________________
☐ Other	______________________

Drug Class	Document Drug Name/Dosage/Duration
☐ **INJECTIBLE / IV THERAPY**	
☐ Growth Hormone Replacement Product (**Required Document- Lab test results/Growth Chart)**	______________________
☐ Immunologic agents for Psoriasis and Rheumatoid Arthritis (**Required document for RA - Lab Report)**	______________________
	______________________
☐ Hyaluronic Acid Derivative for Osteoarthritis (**Required document – X-ray results)**	______________________
	______________________
☐ Intravenous Immunoglubin (IVIG)	______________________
☐ Synagis	______________________
☐ Blood Clotting products	______________________
	______________________

☐ **OTHER** ______________________ ☐ Other ______________________

Member ID: ☐☐☐☐☐☐☐☐☐☐ Patient's Name: ______________________

♦♦

Initial Drug Therapy ☐ Yes ☐ No Renewal Treatment ☐ Yes ☐ No

♦♦

ICD-9 Diagnosis Code(s) & Description Principal: ______________ Secondary: ______________

______________ ______________

Pertinent History:

____

____

____

Prior treatment/ medication therapy and outcomes:

____

____

____

____

Comments: ____

____

____

____

♦♦

Request Submitted By: ______________________Request Date: ______________

Name of Prescribing Physician: ______________________ TIN # (Tax ID): ______________

Telephone: (________) ________ - ________ MD Fax #: (________) ________ - ________

Physician Signature: ______________________ Date: ____ / ____ / ____

Physician Specialty:______________________

Office Address:

____

____

____

Member ID: | | | | | | | | | | | **Patient's Name:** ______________________________

Name of Pharmacy providing service: _______________________________ Pharmacist: __________________________________

Office Address: ____

____

Telephone: ____ Fax: ____

Please note: Any areas that are not filled out will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST.

Complete this form and attach copies of pertinent medical documentation or copies of the physician's actual office chart to support your request. Fax completed form to (646) 473-7469.

The Fund's Pre-Authorization Call Center is available Monday to Friday, 9:00 AM to 5:00PM at (646) 473-7446.

Pre-authorization requirements are regularly updated and are therefore subject to change; periodically visit the website at www.1199SEIUBenefits.org for our most recent pre-authorization requirements, authorization request forms and other pertinent information located in the "For Providers" section.