Clinic-Administered Medication Prior Authorization Request Form

2650 Novation Pkwy • Fitchburg, WI 53713
Fax 608-471-4389
QuartzBenefits.com

Prior to completing this form, call a Quartz Customer Success Representative at **(800) 362-3310**, to verify benefits and eligibility for the member. Services are not considered authorized until a determination of coverage is completed by Quartz.

Complete and send to us by:

- **MyQuartzTools.com**
- Mail: Quartz Pharmacy Program; 2650 Novation Pkwy, Fitchburg, WI 53713
- Fax: 608-471-4389

Date completed: _____

Member information (please print)

Name:	Quartz Member ID number:	Date of birth:

Diagnosis:

Services requested:

HCPCS / CPT Codes:

Provider Information (please print)

Requesting provider:

Phone:	Fax:

Clinic Contact:

Referred to Provider:

Site/Location:

Phone:	Fax:

Reason for request (Be as specific as possible)

Supporting medical documentation attached? (Check one.) ☐ Yes ☐ No Number of pages: _____

Urgent Requests

☐ **REQUEST FOR EXPEDITED REVIEW:** By checking this box, I certify that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*Documentation must be provided above from the PRESCRIBER indicating why the request is Urgent/Expedited. Without documentation to support urgency, request may be treated as a standard request.

Prescribers will be notified by fax and members will be notified by mail when a decision has been determined.