



Durlaza™ Prior Authorization Request Form

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Chronic coronary artery disease (CAD)	
<input type="checkbox"/> Ischemic stroke	
<input type="checkbox"/> Transient ischemic attack	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

Clinical information:
 Has the patient had a 90 day trial and failure with immediate release aspirin? Yes No
 Please submit clinical rationale explaining why a failure with the extended-release product is not expected:

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-855-401-4262.
 This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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