

Qualaquin[®] (quinine) Prior Authorization Request Form DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)			
Member Name:			Provider Name:			
Insurance ID#:			NPI#:		Specialty:	
Date of Birth:			Office Phone:			
City: State: Zip:			Office Fax:			
City:	State:	Zip:	Office Street Address:			
Phone:			City:	State:	Zip:	
Medication Information (required)						
Medication Name:		Strength:		Dosage Form:		
Check if requesting brand			Directions for Use:			
Check if request is for continuation of therapy						
Clinical Information (required)						
Select the diagno	osis below:					
Malaria						
Other diagnosis:			_ ICD-10 Code(s):			
	ty requested per D		_			
What is the reason for exceeding the plan limitations?						
 Titration or loading dose purposes Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two 						
Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at hight, one to two tablets at bedtime)						
Requested strength/dose is not commercially available						
Other:						

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

This request may be denied unless all required information is received. Please note: 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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