General Prior Authorization (PA) Intake Form

How to request a Prior Authorization Request Form:

1. **Complete and sign this form.** If the following information is not complete or legible, it may delay the process.
2. **Send the completed form to Flipt via fax at 1-551-298-4368 OR via email at WeCare@fliptrx.com**.

Member Information		Prescriber Information	
Member Name:		**Prescriber Name:**	
Flipt Member ID:		**Prescriber NPI:**	
Date of Birth:		**Address:**	
Address:		**City:**	
City:		**State:**	**Zip Code:**
State:	**Zip Code:**	**Office Phone:**	
Phone:		**Office Secure Fax:**	

Medication Information		
Name:		**Strength:**
Dosage Form:	**Quantity:**	**Day Supply:**
** Please do not include clinical attachments. Flipt will send a PA Request Form if a PA is required **		

Name of Requester: _____

Prescriber Signature (Required): _____ **Date:** _____

(I attest that the information provided is true and accurate and understand that Flipt may perform a routine audit.)

Upon receipt, Flipt will provide a response within 24 business hours, excluding weekends and holidays.

Revision Date: 012023