

**PM FORM 3.16.11**  
**NARBHA PRESCRIBER AND TEMPORARY PRESCRIBER REGISTRATION FORM**

TO: **Northern Arizona Regional Behavioral Health Authority**  
**FAX: (855) 411-7559                      ATTN: Pharmacy Support**

FROM: PRINT NAME: \_\_\_\_\_ Provider Agency \_\_\_\_\_

DATE: \_\_\_/\_\_\_/\_\_\_      FAX # of Sender: \_\_\_\_\_

Please **ADD** the following prescriber to the NARBHA Authorized Prescriber Panel  
 NARBHA-Contracted Behavioral Health Facilities or Medical Practitioners may submit the form but are strongly encouraged to first contact NARBHA Pharmacy Support to determine if a prescriber is already on the prescriber panel and to be referred to the NARBHA Medical Director to answer questions about the formulary. New prescribers will be mailed a New Prescriber Orientation Packet and are required to submit an attestation that the packet has been reviewed.

**\*\*\*PLEASE PRINT\*\*\***

Type of Prescriber Addition:	(circle one): <b>Regular</b> or <b>Temporary</b>
<b>Please note: NARBHA can only authorize a temporary prescriber for a period of 5 days.</b>	
Prescriber Name (PRINT PLEASE)	_____
DEA Number	_____
NPI Number	_____
Effective Start Date	_____/_____/_____
Prescriber Address if Different from Provider	_____

Please **DELETE** the following prescriber from the NARBHA Authorized Prescriber Panel  
 Be sure to consider outstanding valid prescriptions by the prescriber including refills when deciding on the stop date.

Prescriber Name (PRINT PLEASE)	_____
DEA Number	_____
NPI Number	_____
Effective Stop Date	_____/_____/_____

**AUTHORIZATION**

**NARBHA-Contracted Behavioral Health Facility or Provider:** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Authorized by (print name):** \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_