FAX COMPLETED FORM TO:
1-563-293-8156
QUESTIONS PLEASE CALL:
1-888-884-6331

Prescription Drug Prior Authorization Form

EOC ID: «EOC ID»

Prescriber Name:	«Prescriber Name»	**Plan:**	«Client ID»: «Client Name»
Prescriber Phone:	«Prescriber Phone»	**Prescriber Fax:**	«Prescriber Fax1»
Patient Name:	«Patient Name»	**Patient ID:**	«Member Id»
DOB:	«Patient DOB»	**Date:**	«Request DateTime»

********************FAILURE TO COMPLETE FORM MAY RESULT IN AUTOMATIC DENIAL********************

Drug Name: «HCS Name» «HCS Dosage»

QTY / DS: «HCS Quantity» for «Days Supply» days

Directions: «HCS1 Direction»

Start Date: _____

Diagnosis: _____

ICD-10 Code: _____

*****Chart Notes from Physician Required to Document Failure in Order to Override Benefit*****

Complete the Following for Previous Treatment(s) for the Same Condition:

Treatment/Drug Used	Date(s) Used	Results
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Prescriber Comments: _____

Prescriber Signature: _____ Date: _____