



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: _____

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