PRESCRIPTION DRUG PRIOR AUTHORIZATION FORM

Fax Completed Form To: 563-293-8156 | For Questions Please Call: 866-335-9057

Standard Form

Prescriber Name: _____ Prescriber NPI: _____

Prescriber Phone: _____ Prescriber Fax: _____

Patient Name: _____ Patient ID: _____

DOB: _____ Date: _____

Failure to fully complete this form may result in denial.

Drug Name: _____

Strength: _____

Directions: _____

Duration of Therapy: _____

Indication: _____

Diagnosis Code: _____

Physician chart notes documenting failure are required in order to override the benefit.

Complete the following for previous treatment(s) for the same condition:

Treatment/Drug Used	Date(s) Used	Results

Prescriber Comments: _____

_____

Prescriber Signature or Name/Title of Staff Member: _____