

# 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:** \_\_\_\_\_

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