



P.O. Box 431
2495 E National Hwy
Washington, IN 47501

866-921-4047
customerservice@truerox.com
truerox.com

PRIOR AUTHORIZATION REQUEST FORM

Please fax to (812) 254-7426

PLEASE NOTE - The request must include:

1. Electronic office notes that correlate to the diagnosis (hand-written office notes must include a letter of medical necessity)
2. List of all drug therapies tried and failed for the diagnosis (Section E can be completed in place of requirement #2)
3. This form must be completed in full to process

Request Date: _____

Section A: Patient Information					
Patient Name: (Last, First)		DOB: (mm/dd/yyyy)		Age:	Gender:
Card ID #:	Self <input type="checkbox"/>	Spouse <input type="checkbox"/>	Dependent <input type="checkbox"/>	Height:	Weight:
Address:		City, State, Zip:			Phone:
Section B: Prescriber Information					
Prescriber Name:			Phone:		
Contact Person:			Fax:		
Address:		City, State, Zip:			
Section C: Medication Request					
Diagnosis/Indication:			Drug Name & Strength:		
Sig:	Qty:	Days Supply:	Refills (# or N/A)		
New Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Expected Duration of Therapy	Last Evaluation Date (mm/dd/yyyy)	Next Appointment Date (mm/dd/yyyy)		
Section D: Medical History					
Include Laboratory results, Physical exam findings and Associated Risk Factors as applicable: (ex: A1c for diabetes, lipid and liver panel for cholesterol, viral loads and CD4 counts for HIV), attach additional if needed.					<input type="checkbox"/> N/A
Is the patient on other prescription medications <u>currently</u> to treat this diagnosis? * If yes, please identify: Medication, Strength, Directions					<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the patient on other non-prescription therapies <u>currently</u> to treat this diagnosis? * If yes, please identify: Therapy					<input type="checkbox"/> Yes <input type="checkbox"/> No
Have any other prescription medications been <u>tried in the past</u> for this diagnosis? * If yes, please identify: Medication, Strength, Directions, Reason Discontinued, Date Discontinued					<input type="checkbox"/> Yes <input type="checkbox"/> No
Have any other non-prescription therapies been <u>tried in the past</u> for this diagnosis? * If yes, please identify: Therapy					<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the disease/diagnosis/condition have staging or an assessment of severity? (Ex: % of body covered for psoriasis) * If yes, please indicate the extent/severity of the disease/condition					<input type="checkbox"/> Yes <input type="checkbox"/> No

For office use only beyond this line _____

Patient Employer: _____ Group #: _____
Employee Copay: _____ Plan Cost Per Supply: _____

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