trueRx
HEALTH STRATEGISTS

PRIOR AUTHORIZATION REQUEST FORM

Fax to (812) 254-7426

Please note the request MUST include:

1. **Office notes**
   - Electronic office notes correlating to the diagnosis or
   - Hand-written office notes including a letter of medical necessity.
2. List all drug therapies tried and failed for the diagnosis.

Request Date:

Section A: Patient Information

Patient Last Name:	Patient First Name:	DOB: (mm/dd/yyyy)	Age:	Gender:
Card ID #:	Self ☐ Spouse ☐ Dependent ☐		Height:	Weight:
Address:	City, State, Zip:		Patient Phone:	

Section B: Prescriber Information

Prescriber Name:	Prescriber Phone:
Contact Person:	Prescriber Fax:
Address:	City, State, Zip:

Section C: Medication Request

Drug Name & Strength:			
Diagnosis/Indication:			
Directions:	Qty:	Days Supply:	Refills (# or N/A):

New Therapy: ☐ Yes ☐ 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. Attach additional information if needed.	☐ N/A	
Is the patient on other prescription medications **currently** to treat this diagnosis? If yes, please identify medication, strength, and directions in section E.	☐ Yes	☐ No
Is the patient on other non-prescription therapies **currently** to treat this diagnosis? If yes, please identify therapy.	☐ Yes	☐ No
Have any other prescription medications been **tried in the past** for this diagnosis? If yes, please identify medication, strength, directions, reason discontinued, and date discontinued in section E.	☐ Yes	☐ No
Have any other non-prescription therapies been **tried in the past** for this diagnosis? If yes, please identify therapy.	☐ Yes	☐ 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.	☐ Yes	☐ No

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Section E: Relevant Drug History and Additional Notes:

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