PR CRIPTION DRUG PRIOR AUT ORIZAT

Contains Confidential Pati

Complete form an

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|Indiana - 44-5 - 94 **| Kent**

|Nevada - 44-5s

|Wisc

Patient Name:

Patient Information: This must be filled out completely to ensure IPAA compliance

PR CRIPTION DRUG PRIOR AUT ORIZATION R QU T FORM

Contains Confidential Patient Information

Instructions: Plea e ill out all applicable ection on both page completel and legibl . Attach an additional documentation that i important or the review, e.g. chart note or lab data, to upport the prior authorization reque t.

Prescriber Information			
Fir t Name:	La t Name:	Specialt :	
Addre :	Cit :	State:	Zip Code:
Reque tor (i di erent than pre criber):	O ice Contact Per on:		
NPI Number (individual):	Phone Number:		
DEA Number (i required):	Fax Number (in HIPAA compliant area):		
Email Addre :			

Medication / Medical and Dispensing Information
Medication Name (li t all that appl):

☐New Therap ☐Renewal

I Renewal: Date Therap Initiated: Duration o Therap (peci ic date):

☐Copa review (provide detail): _____

☐Maine: Proactive Non- ormular reque t t