



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.
3. Patient phone number

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:		NPI Number:		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 ☐ Yes ☐ No If yes, please indicate the extent/severity of the disease/condition.					



Section E: Relevant Drug History and Additional Notes:

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