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

P.O. Box 431
Washington, IN 47501
866-921-4047
hello@truerx.com

Section E: Relevant Drug History and Additional Notes:

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