# PRESCRIPTION DRUG PRIOR AUTHORIZATION FORM

**Fax Completed Form To: 563-293-8156 | For Questions Please Call: 866-335-9057**

## Standard Form

Prescriber Name: _____ Prescriber NPI: _____

Prescriber Phone: _____ Prescriber Fax: _____

Patient Name: _____ Patient ID: _____

DOB: _____ Date: _____

## Failure to fully complete this form may result in denial.

Drug Name: _____

Strength: _____

Directions: _____

Duration of Therapy: _____

Indication: _____

Diagnosis Code: _____

## Physician chart notes documenting failure are required in order to override the benefit.

**Complete the following for previous treatment(s) for the same condition:**

| Treatment/Drug Used | Date(s) Used | Results |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Prescriber Comments:** _____

_____

**Prescriber Signature or Name/Title of Staff Member:** _____

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