CLINICAL REVIEW / PRIOR AUTHORIZATION REQUEST FORM

*** Required Information**

TrueScripts™

Please Fax to: (812) 257-1968

Please Note: MUST be filled out by prescriber's office. If the following information is not filled in completely, correctly, or legibly, the authorization review will be delayed. Please allow 24 business hours for processing.

513 E. South St.~ Washington, IN 47501~ Toll Free (844)-257-1955~ Fax (812)-257-1968~ After Hours (855)-326-2159 ~

Patient Information

*Patient Full Name:		*Cell Phone #	
*Address:		Alt. Phone #	
Address 2		E-mail	
*City		*Height	*Weight
*State	*Zip Code	*Known Allergies	
*Date Of Birth	*Gender	*Last 4 of SSN	

Insurance Information:

*Cardholder Name:		BIN 017274	PCN PDMI
Prescription Group # on Card		Relationship	Person Code
*Cardholder ID # on Card		Number in Household	

Household Income

☐ $0-$30,000 ☐ $30,001-$45,000 ☐ $45,001-$60,000 ☐ $60,001-$80,000 ☐ $80,001-$100,000 ☐ $100,001-$125,000 ☐ $125,001-$150,000 ☐ $150,001 or more

Prescriber Information:

*Prescriber Name		*Prescriber NPI	
*Address		Address 2	
*City	*State		*Zip Code
*Phone Number		*Fax Number	
*Office Contact		*Prescriber Signature	
*Prescriber Specialty			

Medication Information:

☐ New ☐ Renewal

*Medication Name		*Strength	
*Diagnosis (ICD 10)		*Quantity	
*Delivery Location		*Date Needed	
*Anticipated Length of Therapy		*Day Supply	

*Tried/Failed Therapies For This Request ☐ N/A

Previous Medication	Strength	Sig.	Start/End Date	Results
Previous Medication	Strength	Sig.	Start/End Date	Results
Previous Medication	Strength	Sig.	Start/End Date	Results

Attach additional information for other medications tried/results, or any material related to this request (medical history, labs, etc.)