

**CLINICAL REVIEW / PRIOR AUTHORIZATION REQUEST FORM**



**\* Required Information**

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.

**Please Fax to: (812) 257-1968**

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

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

<b>Insurance Information:</b>			
<b>*Cardholder Name:</b> _____ <b>Prescription Group # on Card</b> _____ <b>*Cardholder ID # on Card</b> _____ <b>Household Income</b>	<b>BIN</b> <u>017274</u> <b>Relationship</b> _____ <b>Number in Household</b> _____	<b>PCN</b> _____ <b>Person Code</b> _____	<b>PDMI</b> _____ _____
Household Income <input type="checkbox"/> \$0-\$30,000 <input type="checkbox"/> \$45,001-\$60,000 <input type="checkbox"/> \$80,001-\$100,000 <input type="checkbox"/> \$125,001-\$150,000 <input type="checkbox"/> \$30,001-\$45,000 <input type="checkbox"/> \$60,001-\$80,000 <input type="checkbox"/> \$100,001-\$125,000 <input type="checkbox"/> \$150,001 or more			

<b>Prescriber Information:</b>			
<b>*Prescriber Name</b> _____ <b>*Address</b> _____ <b>*City</b> _____ <b>*State</b> _____ <b>*Phone Number</b> _____ <b>*Office Contact</b> _____ <b>*Prescriber Specialty</b> _____	<b>*Prescriber NPI</b> _____ <b>Address 2</b> _____ <b>*Zip Code</b> _____ <b>*Fax Number</b> _____ <b>*Prescriber Signature</b> _____		

<b>Medication Information:</b>			
<b>*Medication Name</b> _____ <b>*Diagnosis (ICD 10)</b> _____ <b>*Delivery Location</b> _____ <b>*Anticipated Length of Therapy</b> _____	<b>*Strength</b> _____ <b>*Quantity</b> _____ <b>*Date Needed</b> _____ <b>*Day Supply</b> _____	<input type="checkbox"/> New <input type="checkbox"/> Renewal	

<b>*Tried/Failed Therapies For This Request</b> <input type="checkbox"/> N/A				
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.)**

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