



PRIOR AUTHORIZATION REQUEST FORM

4 Williams Bros Dr ~ Washington, IN 47501 ~ (866) 921-4047 ~ (812) 254-7425 ~ (812) 254-7426 fax

Please Fax to: (812) 254-7426

Employer _____ Request Date _____

Authorization Request For

Self Spouse Dependent

Name _____ DOB _____ Gender _____ Height _____

ID # _____ Group # _____ Weight _____

Cardholder Name _____

Phone _____ Alt. Phone _____

Address _____

City _____ State _____ Zip _____

Doctor Information

Doctor Name _____ Phone # _____

Address _____

City _____ State _____ Zip _____

Requested Medication Information

Requested Drug _____ Strength _____ Qty _____

Employee Co-pay _____ Plan Cost Per Supply _____

Diagnosis _____

OTHER MEDICATIONS TRIED AND RESULTS

Previous Medication	Strength	Sig.	Duration(start/end date)	Results
Previous Medication	Strength	Sig.	Duration(start/end date)	Results
Previous Medication	Strength	Sig.	Duration(start/end date)	Results

Plan Limits _____ Other: _____

PA Time Frame One Year Six Months Other (specify time frame or Plan limit \$ value)

For office use only beyond this line **Research & attach drug Indication, Usage, and Dosage documentation.**

APPROVED REJECTED Reason _____

Clinical Review Team notes regarding blocks _____
to put in place / other suggestions: _____

Employer or authorized plan representative please print name, provide title, sign and date below

Signature (required) _____ Date _____

Printed Name _____

Title _____ Phone # _____

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Requested Drug	Alternative
Lowest UOI in Cardinal	
Current MAC Price (for generics only)	
Total Cost of Drug	