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 # _____

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