PRIOR AUTHORIZATION REQUEST FORM

TRUE Rx
Health Care for Your Business

Must be completed in full to process

7 Williams Brothers Drive ~ Washington, IN 47501 ~ (866) 921-4047 ~ (812) 254-7426 fax

PLEASE NOTE - The request must include:

1. Electronic office notes that correlate to the diagnosis (hand written office notes must include a letter of medical necessity)
2. List of all drug therapies tried and failed for the diagnosis (Section E can be completed in place of requirement #2)
3. This form must be completed in full to process

Please Fax to: (812) 254-7426

Request Date: _____

Section A: Patient Information

Patient Name: (Last, First)	DOB: (mm/dd/yyyy)	Age:	Gender:
Card ID #:	☐ Self ☐ Spouse ☐ Dependent	Height:	Weight:
Address:	City, State, Zip:	Phone:	

Section B: Prescriber Information

Prescriber Name:	Phone:
Contact Person:	Fax:
Address:	City, State, Zip:

Section C: Medication Request

Diagnosis/Indication:	Drug Name & Strength:		
Sig:	Qty:	Days Supply:	Refills (# or N/A)
☐ New Therapy Yes ☐ No / Expected Duration of Therapy	Last Evaluation Date (mm/dd/yyyy)		Next Appointment Date (mm/dd/yyyy)

Section E: Medical History

Include Laboratory results, Physical exam findings and Associated Risk Factors as applicable: (ex: A1c for diabetes, lipid and liver panel for cholesterol, viral loads and CD4 counts for HIV), attach additional if needed. ☐ N/A

Is the patient on other prescription medications currently to treat this diagnosis? ☐ Yes ☐ No
* If yes, please identify: Medication, Strength, Directions

Is the patient on other non-prescription therapies currently to treat this diagnosis? ☐ Yes ☐ No
* If yes, please identify: Therapy

Have any other prescription medications been tried in the past for this diagnosis? ☐ Yes ☐ No
* If yes, please identify: Medication, Strength, Directions, Reason Discontinued, Date Discontinued

Have any other non-prescription therapies been tried in the past for this diagnosis? ☐ Yes ☐ No
*If yes, please identify: Therapy

Does the disease/diagnosis/condition have staging or an assessment of severity? (Ex: % of body covered for psoriasis) ☐ Yes ☐ No
* If yes, please indicate the extent/severity of the disease/condition

For office use only beyond this line

Patient Employer: _____ Group #: _____

Employee Co-pay: _____ Plan Cost Per Supply: _____

☐ APPROVED ☐ DENIED REASON: _____

Revised 06.2019