

Attach pertinent Clinical Notes, H&P, and/or applicable labs from the last 6 months

CLINICAL REVIEW / PRIOR AUTHORIZATION REQUEST FORM



Please Fax to: (812) 257-1968

**\* 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 denied. Please allow 24-48 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 Name:	_____	*Cell Phone #	_____
*Address:	_____	Alt. Phone #	_____
Address 2	_____	E-mail	_____
*City	_____	*Height	_____
*State	_____	*Weight	_____
*Zip Code	_____	*Known Allergies	_____
*Date Of Birth	_____	*Last 4 of SSN	_____
*Gender	_____		

**Insurance Information:**

*Cardholder Name: (On card)	_____	BIN	_____	PCN	_____
Prescription Group # on Card	_____	Relationship	_____ (Cardholder, Spouse, Dependent)		
*Cardholder ID # on Card	_____	Secondary Insurance	_____		

**Prescriber Information:**

*Prescriber Name	_____	*Prescriber NPI	_____
*Address	_____	Address 2	_____
*City	_____	*State	_____
*Phone Number	_____	*Zip Code	_____
*Office Contact	_____	*Fax Number	_____
*Prescriber Specialty (i.e. oncology, etc.)	_____	*Prescriber Signature	_____

**Medication Information:**

☐ New ☐ Renewal

*Medication Name	_____	*Strength	_____
*Diagnosis (ICD 10)	_____	*Quantity	_____
*Delivery Location	_____	*Date Needed	_____
	(Member Address, MD Office, Infusion Clinic, N/A, etc.)	*Day Supply	_____
*Anticipated Length of Therapy	_____	<input type="checkbox"/> Please check if the patient has been receiving samples of this medication?	
*Instructions for use	_____		

If this request is for Ozempic or Mounjaro and the diagnosis is NOT Type 2 Diabetes and patient's A1c is under 6.5, it's an automatic denial and you will not be notified.

**\*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

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