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

TrueScripts™

Please Fax to: (812) 257-1968

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 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 _____ *Weight _____

*State _____ *Zip Code _____ *Known Allergies _____

*Date Of Birth _____ *Gender _____ *Last 4 of SSN _____

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 _____ *Zip Code _____

*Phone Number _____ *Fax Number _____

*Office Contact _____ *Prescriber Signature _____

*Prescriber Specialty (i.e. oncology, etc.) _____

Medication Information:

☐ New ☐ Renewal

*Medication Name _____ *Strength _____

*Diagnosis (ICD 10) _____ *Quantity _____

*Delivery Location _____ *Date Needed _____

(Member Address, MD Office, Infusion Clinic, N/A, etc.)

*Anticipated Length of Therapy _____ *Day Supply _____

*Instructions for use _____

☐ Please check if the patient has been receiving samples of this medication?

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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