Letter of Medical Necessity Prior Authorization Request Form

Fax Completed Form to 740-305-0596

If Urgent, please call 740-661-4463 (M-F 9am-7pm EST)

alius health
The difference is clear

Patient Information

Injured Worker's Name:
Injured Worker's Date of Birth:
Claim #: _____
Date of Injury:
Member ID:

Prescriber Information

Prescriber Name: _____
Prescriber NPI:
Prescriber Phone:
Prescriber Fax:

[Patient/IW] is under my care for the treatment of ICD 10:

This treatment is related to the patient's workers' compensation injury: ☐ Yes ☐ No

Please list Medications that have been prescribed and tried in the past, if any:

This Request is for: (Name of Medication) _____

Strength: _____ Quantity: ____ Day Supply: _____ Route of Administration: _____

Pharmacy Name and Location (if known): _____ Phone: _____

Claimant is unable to take the formulary medications/preferred medications because of:

☐ An adverse reaction. Please describe:
☐ A drug-drug interaction. Please list:
☐ A contraindication because of ☐ liver or ☐ kidney disease
☐ Inadequate response to preferred agent:
☐ Other:
☐ This medication is medically necessary because:

Physician Signature **Date**