Prior Authorization Request Form
Standard for All Non-opioid Drugs

Fax Completed Form to 740-305-0596

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

Patient Information

Name: ________________________________

Date of Birth: _________________________

Claim #: ______________________________

Date of Injury: ________________________

Prescriber Information

Name: ________________________________

NPI: _________________________________

Phone: _______________________________

Fax: _________________________________

The patient is under my care for the treatment of ____

ICD 10 Code(s): ____

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

This Request is for (medication): ____

Quantity_____ Day Supply: ______ Brand Medically Necessary: ________

If Brand Medically Necessary marked, please explain why: ____________________________

____

NOTE:

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

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**

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