



**WORKER'S COMPENSATION PREAUTHORIZATION REQUEST FOR PRESCRIPTION DRUG BENEFITS
FAX COMPLETED FORM TO 888-777-8272**

Date	Claimant Name		Date of Birth		
Address			Date of Injury		
Employer		Claim#	First Responder (Fire, Police, EMS) <input type="checkbox"/> Yes <input type="checkbox"/> No		
REQUESTING PROVIDER OR FACILITY					
Name		Phone	Fax		
Contact Name		NPI Number	Tax ID		
Address		City	State/Zip Code		
ORDERING PHYSICIAN			PLACE OF SERVICE		
Name			Name		
NPI	Tax ID	NPI	Tax ID		
Phone	Fax	Phone	Fax		
Address			Address		
PRESCRIPTION DRUG INFORMATION (For all compound drug(s), identify all ingredients below.)					
Requested Drug Name:					
Strength:	Route of Administration:	Quantity:	Days' Supply:	Expected Therapy Duration:	
To the best of your knowledge this medication is: <input type="checkbox"/> New Therapy <input type="checkbox"/> Continuation of therapy (approximate date therapy initiated: _____)					
For Provider Administered Drugs Only: HCPCS Code: _____ NDC#: _____ Dose Per Administration: _____					
Compound Drug Name:					
Ingredient	NDC#	Quantity	Ingredient	NDC#	Quantity



PRESCRIPTION DEVICE INFORMATION

Requested Device Name	Expected Duration of Use:	HCPCS Code (If applicable):

PATIENT CLINICAL INFORMATION

Patient's diagnosis related to this request:	ICD Version:	ICD Code:
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(Provide the following information to the best of your knowledge)

Drugs patient has taken for this diagnosis:

Drug Name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason for Failure, or Allergy

Drug Allergies:	Height (if applicable):	Weight (if applicable):
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Relevant laboratory values and dates (attach or list below):

Date	Test	Value

**ATTACH CLINICAL DOCUMENTATION AND PHYSICIAN SIGNED ORDERS
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