PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Instructions: The Workers' Compensation insurance carrier handling the below injury is requesting a summary of medical necessity from the treating physician describing how medication is related to the injury. Please note that failure to respond to this request may result in the denial of coverage for the medication. You may attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support this request.

Patient Information

Name: Luke Skywalker

Date of birth: 07/07/1977	☒ Male ☐ Female	Phone: (740) 565 - 1987

Current address: 65 Main St PO Box 65

City: Dublin	State: OH	ZIP Code: 43106

Worker's Compensation Claim Information

Insurance Carrier: Medical Mutual

Employer: Bob's Used Car Lot

DOI: 10/01/2017	Claim#: #567XY24	ICD10: W.04.12

Provider Information

Provider's Name: Dr Bob	Provider Id Number: #QX678Z86
Phone: (746) 222 - 5687	Fax: (746) 254 - 9712

Medication Information

Medication Name/Strength: Tylenol 500mg		#Refills: 6
Qty: 90	Day Supply: 30	☒ New Therapy ☒ Renewal If Renewal: Date Therapy Initiated: 10/05/2017 Duration of Therapy: 6 months

Prescribed Indication:

Prescriber Signature:	Date:

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