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:		
Date of birth:	☐ Male ☐ Female	Phone:
Current address:		
City:	State:	ZIP Code:

Worker's Compensation Claim Information

Insurance Carrier:		
Employer:		
DOI:	Claim#:	ICD10:

Provider Information

Provider's Name:	Provider Id Number:
Phone:	Fax:

Medication Information

Medication Name/Strength:			#Refills:
Qty:	Day Supply:	☐ New Therapy ☐ Renewal If Renewal: Date Therapy Initiated:	Duration of Therapy:
Prescribed Indication:			

Prescriber Signature:	Date: