

MEDICATION PREAUTHORIZATION REQUEST PHYSICIAN FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

PLEASE INCLUDE APPLICABLE CHART NOTES, LABORATORY RESULTS and RADIOLOGY FINDINGS

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration.

Does this member have a cancer diagnosis? Yes No

PATIENT INFORMATION

Today's Date:

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:		City, State, Zip:	Patient Telephone:

INSURANCE INFORMATION

Member ID Number:	Group Number:
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PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

Patient's Diagnosis (ICD Code plus Description):	
Medication Requested:	Strength:
Dosing Schedule (Frequency):	Quantity per Month:
Route of Administration:	Expected Length of Therapy
1. Has the patient been on this medication in the past 6 months? Yes No Start date: _____	
2. Has the patient tried and had an inadequate treatment response or intolerance to first line agents? Yes No Please list: _____	
3. Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? Yes No	
4. Has the patient had appropriate laboratory and/or genetic testing to support the diagnosis? Yes No	
5. <i>Renewals only:</i> Has the patient improved while on this treatment? Yes No	
6. Have chart notes been attached to this request? (Required) Yes No	
Please fax or mail this form to: WEA Trust PO Box 21538 Eagan MN 55121 Fax: 608-276-9119 Phone: 800-279-4090	CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone at 608-661-6706 and return the original message to Archimedes via U.S. Mail. Thank you for your cooperation.

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