LDI Integrated Pharmacy Prior Authorization Form

integrated pharmacy services

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StayWell INSURANCE

PATIENT INFORMATION		
LAST NAME	FIRST NAME	
DATE OF BIRTH	SEX	
PRESCRIBER INFORMATION		
PRESCRIBER NAME	DEA/NPI	
TEL	FAX	
PRESCRIBER SPECIALTY		
MEDICATIONS	DOSAGE	QUANTITY
DIRECTIONS		

DIAGNOSIS

Is the patient a new start?

☐ YES

☐ NO If NO, how long has the patient been on the current therapy? _____

Proposed length of treatment _____

Please list other medications the patient has tried to treat this condition

_____

_____

* Please submit relevant chart notes and labs showing clinical need for medication requested or evidence of continued efficacy

COMMENTS

_____

_____

_____

_____ _____

PRESCRIBER OR AUTHORIZED SIGNATURE **DATE**