Please complete ALL information below and fax your request to 1-888-671-5285

Dispense As Written (DAW) Override Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

What is the patient's diagnosis for the medication being requested? _____

ICD-10 Code(s): _____

Medication history:

Please list ALL generic equivalents of the requested drug that the patient has tried and failed:_____

_____

Please specify the number of generic equivalents from different manufacturers the patient has tried: _____

Has the patient had an allergic reaction or intolerance to an inactive ingredient? ❑ **Yes** ❑ **No**

Has the patient experienced an inadequate response to the generic equivalent? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.