NIH Clinical

CLINICAL AND PHARMACY MSO - INFUSION - CLINICAL TRIALS

PRIOR AUTHORIZATION REQUEST

Instructions: Please complete this form in its entirety to initiate a prior authorization on behalf of our mutual patient. Once completed, please fax this form and supporting documentation to 515-518-6704. For questions, call 515-518-6654 our team is here to help.

Patient Information:

Name	
Date of Birth	
Phone	

Provider Information:

Provider Name			
Credentials			
Specialty			
NPI			
Phone		Fax	

Urgent Request:

Is the provider requesting an urgent review? ☐ YES ☐ NO

*For this purpose, urgent is defined as when the provider believes that if the request were to take the standard review window period (up to 3 business days) awaiting a final decision that it could put the patient's life, health, or ability to regain function in jeopardy

Medication Information:

Medication and Strength: _____

Directions: _____

Quantity and Day Supply: _____

Primary ICD-10 Code: _____ Secondary ICD-10 Code: _____

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PRIOR AUTHORIZATION REQUEST

Medical Necessity Segment

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Type of Prior Authorization Request:

- ☐ New start to requested therapy
- ☐ Continuation of requested therapy
- ☐ Medical review
- ☐ Pharmacy review

Supporting Documentation Included (Check all that apply)

- ☐ Most Recent History & Physical/Office Visit Note
- ☐ Most Recent Imaging
- ☐ Most Recent Labs
- ☐ Current Medication List
- ☐ Pharmacy fill history
- ☐ Other: _____

Provider Attestation:

By signing this form, I attest that the information provided is accurate and complete to the best of my knowledge.

Provider Signature: _____ **Date:** _____