NIH Clinical

CLINICAL AND PHARMACY MSO - INFUSION - CLINICAL TRIALS

PRIOR AUTHORIZATION APPEAL FORM

Patient Information:

Name	
Date of Birth	
Member ID	
Phone	
Email	

Provider Information:

Provider Name			
Credentials			
Specialty			
NPI			
Phone		Fax	

Medication Information:

Medication and Strength: _____

Directions: _____

Quantity and Day Supply: _____

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

Appeal Instructions:

To appeal an initial prior authorization denial, the requesting provider must submit a Letter of Medical Necessity (LMN) in addition to updated patient records. Please fax completed forms, documents, and a copy of the intial denial letter to NIH Clinical at 515-518-6704.

Supporting Documentation Included (Check all that apply):

- ☐ Letter of Medical Necessity ***REQUIRED***
- ☐ Updated office visit notes
- ☐ Updated labs or imaging
- ☐ Peer reviewed literature supporting use
- ☐ Clinical practice guidelines
- ☐ Pharmacy dispensing data
- ☐ Step therapy information
- ☐ Other: _____

Provider Attestation:

By signing this form, I attest that the information provided both within this form and the supporting records are accurate and complete to the best of my knowledge.

Provider Signature: _____ **Date:** _____