

Beneficiary Information

1. Beneficiary Last Name: _____	2. First Name: _____	
3. Beneficiary ID #: _____	4. Beneficiary Date of Birth: _____	5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____	NPI #: _____		
Mailing address: _____	City: _____	State: _____	ZIP: _____
7. Requester Contact Information: _____			
Name: _____	Phone #: _____	Fax #: _____	

Drug Information

8. Drug Name: _____	9. Strength: _____	10. Quantity Per 30 Days: _____
11. Length of Therapy: <input type="checkbox"/> up to 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days <input type="checkbox"/> 180 days <input type="checkbox"/> 365 days <input type="checkbox"/> Other: _____		

Clinical Information

1. Is the beneficiary being treated for a parasitic infection? Yes <input type="checkbox"/> No <input type="checkbox"/>

Signature of Prescriber: _____

Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406