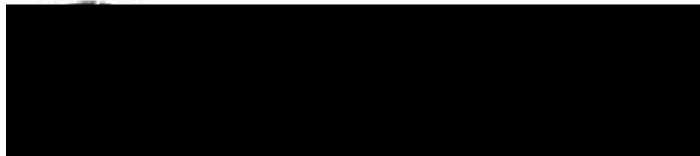


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BL0345  
Bloomington, MN 55439  
PH # 1-800-417-8164

## Prior Authorization Request Form

**FAX to ESI: 800-357-9577**

**Please Note:**

If the following information is NOT filled in completely, correctly or legibly, the authorization review **will be delayed.**



**Insurance Company** \_\_\_\_\_

**Patients Prescription ID#** \_\_\_\_\_

**Patient Full Name** \_\_\_\_\_

**Patient Date of Birth** \_\_\_\_\_

**Medication Requested** \_\_\_\_\_

**Quantity Requested** \_\_\_\_\_ **for** \_\_\_\_\_ **days supply**

**Physician Name (please print clearly)** \_\_\_\_\_

**Physician DEA number (required)** \_\_\_\_\_

**Physician Specialty** \_\_\_\_\_

**Physician Address** \_\_\_\_\_

**Physician Phone** \_\_\_\_\_ **Physician Fax** \_\_\_\_\_

**Diagnosis-Indication-Medical History (reason for use of this medication)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other Medications/Therapies Tried and Reason(s) for Failure** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Office Contact Person** \_\_\_\_\_

Any further information pertaining to this drug request should be included and attached to this form.