



CONTAINS CONFIDENTIAL PATIENT INFORMATION

Dose Optimization

Complete form in its entirety and fax to:
Prior Authorization of Benefits (PAB) Center at (866)-807-6241

1. PATIENT INFORMATION

2. PHYSICIAN INFORMATION

Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION

4. STRENGTH

5. DIRECTIONS

6. QUANTITY PER 30 DAYS

<input type="checkbox"/> _____	<input type="checkbox"/> _____	_____	Specify: _____
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7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is patient intolerant to the recommended drug regimen due to adverse side effects?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is patient able to comprehend the recommended drug regimen?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has patient achieved desired results with the recommended drug regimen?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is this patient able to use the recommended dosage forms? If no, please specify why not _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is patient's dose commercially available as a once daily dose (QD)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is patient's dose being titrated with a twice daily (BID) dose?

****NOTE:** Requests will be approved up to the recommended maximum daily dosing limit that is supported by the FDA for the approved indication, and as approved by the Wellpoint National Pharmacy and Therapeutics Committee. Requests for quantities greater than the maximum daily dose will be reviewed for medical necessity.

Medical Justification: _____

9. PHYSICIAN SIGNATURE

_____ Prescriber or Authorized Signature	_____ Date
<small>Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.</small>	
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