



Date _____

PRIOR AUTHORIZATION FORM

M.D. Last Name: _____	M.D. First Name: _____
Physician Phone: _____	Physician Fax: _____
Patient _____	ID# _____ DOB _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

Complete the following for the drug requested: (Chart notes are REQUIRED)

Drug name: _____ Strength: _____

SIG: _____ Length of Therapy: _____

Disease State: _____ Diagnosis Code: _____

Complete the following for previous treatment(s) for the same condition:
(Chart notes are REQUIRED to document failure from the physician in order to override the benefit.)

Treatment / Drug Used	Date(s) Used	Results

Physician's Comments: _____

Physician's Signature (REQUIRED): _____

**SEND OR FAX COMPLETED FORM TO:
877-329-7279**

**Restat
11900 W. Lake Park Dr.
Milwaukee, WI 53224**

**QUESTIONS PLEASE CALL:
877-526-9906**

www.restat.com

*******DISCLOSURE STATEMENT*******

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Date 9/1/2010