restat
A Dohmen Company

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:

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

www.restat.com

QUESTIONS PLEASE CALL:
877-526-9906