



DATE _____

CLINICAL PRIOR AUTH. REQUEST

CUSTOMER _____

Physician _____ **Phone:** _____ **FAX:** _____

SECTION 1 *(To be completed by RESTAT or patient)*

PATIENT _____ **ID:** _____ **DOB:** _____

SECTION 2 *(To be completed by physician)*

Drug Requested _____

Strength _____ **SIG** _____ **Length of Therapy** _____

Disease State to be treated with this drug: _____ **Diagnosis Code** _____

<u>Previous treatment(s)/drug(s) for same condition</u>	<u>Date(s) Used</u>	<u>Result (success or failure)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

This drug is medically necessary due to _____

Comments: _____

Physician Signature: _____ **Date:** _____

SECTION 3 *(To be completed by RESTAT)*

This authorization is: Approved Denied Deferred Incomplete, need further info

RESTAT Comments: _____

Effective date for this authorization: ___/___/___ **Ending date for this authorization:** _____

RESTAT Authorizing Signature: _____ **DATE** _____

Send or fax completed form to:
FAX: 262-335-6221

RESTAT
Attention: Prior Authorizations
Post Office Box 758
West Bend, WI 53095