



Instructions

- The prescriber should only complete this form.
- Please fax completed form to 866-213-6066.
- To speak with an SXC customer service representative, please call 877-615-6330.

Injured worker information

Request date	BWC claim number
Injured worker name	
Injured worker date of injury	

Prescriber information

Prescriber	Prescriber NPI
Prescriber phone	Prescriber fax number

Medication requested and conditions being treated (Required)

Medication name	ICD-9 code(s)	ICD-9 code description(s)
1.		
2.		
3.		
4.		

Non-sterile compound Sterile compound (pain pump)

Brand name drug: The injured worker has a documented, systemic allergic reaction, which is consistent with known symptoms or clinical findings of a medication allergy and has tried other generic drug(s).

Post surgical medication request

Date of scheduled surgery

Justification for request (Required - attach separate sheet if needed.)

Please document how the medication(s) requested is/are related to the treatment of or the control of symptoms associated with the allowed conditions in the claim.

Prescriber signature (required)	Signature date
---------------------------------	----------------