

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