SERVE YOU Rx DIRECT

Specialty Drug Prior Authorization & Prescription Form

Fax completed form to: **414-410-8181**

Please print

PATIENT INFORMATION

Patient Name: _____ Patient DOB: _____ Height: _____ Weight: _____

Member ID: _____ Allergies: _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Daytime Phone #: _____ Best time to call: _____

Mobile Phone #: _____ Best time to call: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Prescriber Specialty: _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Phone #: _____ Fax #: _____

Office Contact: _____ Office Contact #: _____

CLINICAL INFORMATION

Diagnosis: _____ ICD9 Code: _____

Please list all other medications the patient is currently taking for treatment of this diagnosis: _____

_____

Please list all medications the patient has previously tried and failed for treatment of this diagnosis including reason(s) for discontinuation; and/or provide any other pertinent information: _____

_____

Please attach any additional pertinent information to support diagnosis.

PRESCRIPTION

Medication: _____ Quantity: _____

Directions: _____ Refills: _____

Deliver product to: ☐ Office ☐ Patient's Home ☐ Other:_____

Prescriber's Printed Name: _____

Prescriber's Signature: (sign below)

_____ _____ _____

Dispense as Written Substitution Allowed Date