



HEALTH PLAN

We care for Wisconsin.

UNDERWRITTEN BY WPS HEALTH PLAN, INC.

Drug Pre-Service Authorization Request

Please fax form to: 920-490-6942
Decisions may take up to 15 calendar days to be rendered. If the treating practitioner would like to discuss this case with the reviewer, please call 888-711-1444 or 920-490-6900.

Patient Information

Name: _____ Date: _____

Birth Date: _____ Cardholder ID Number (SSN): _____

Drug Requested

Drug: _____ Duration of Treatment: _____

Reason for Use: _____

Previously Attempted Therapies and Reason for Failure

Drug: _____ Failed Because: _____

Drug: _____ Failed Because: _____

Provider Information

Provider Name: _____ Specialty: _____

Telephone Number: _____ Fax: _____

Note: Requests seeking consideration of coverage for a diagnosis that is outside of a drug's FDA approved indications, must also include clinical studies from peer-reviewed journals.

For Health Plan Use Only

Date Received: _____ Date Reviewed: _____ Reviewed By: _____

Approved Effective Date: _____

Other: _____

Consider Other Formulary Drugs: _____

Practitioner Contacted By: Fax Telephone Date Contacted: _____

PA Type: _____ # of Fills: _____ Days: _____ Expires: _____