



**Medication being provided by (check applicable box below):**

Location/site of drug administration: \_\_\_\_\_

NPI or DEA # of administering location: \_\_\_\_\_

**OR**

Specialty Pharmacy: PropriumRx

**\*\*Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.\*\***

**\*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.\***

Patient Name: \_\_\_\_\_

Member Optima #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**DEA OR NPI #:** \_\_\_\_\_

REVISED/UPDATED: 4/6/2018.; 5/25/2018; 8/17/2018; 10/8/2018