Ohio | Bureau of Workers' Compensation

# Request for Prior Authorization of Medication

**Instructions**

- The prescriber should only complete this form.
- Please fax completed form to 866-213-6066.
- To speak with a customer service representative, call 877-543-6446.

| **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 code(s) | ICD code description(s) |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

☐ Non-sterile compound ☐ Sterile compound pain pump ☐ Sterile compound other

☐ 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).

*A copy of the signed prescription that lists all active pharmaceutical ingredients and indicates the usual and customary cost of the prescription must accompany a non-sterile compound.*

**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 |
|---|---|
| | |