

Ophthalmic Antibiotic-Steroid Combinations Prior Authorization Request Form

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP:
Phone:	Date of Birth:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication New or Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? Yes No

Section B - Physician Information

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Phone:	Fax:	NPI #:	Specialty:

Office Contact Name / Fax Attention to:

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 Code:

Is this member pregnant? Yes No If yes, what is this member's due date? _____

Section D – Clinical Information

Requests for Tobradex S.T. Suspension:
 - Is there a clinical reason the patient can't use the individual agents? Yes No
 If yes, list reason: _____

Explain why the preferred medication(s) wouldn't meet your patient's needs:
 (Please fax additional documentation with this form to assist with the determination of medical necessity)

Section E – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for Failure or Discontinuation

Physician Signature: _____ Date: _____