Clinical Information for Injectable Medications

PART A: Patient/Provider Information – Please Print

Patient Name (Last, First, MI)	Sponsor SSN	Date of Birth (mm/dd/yyyy)
Requesting Provider	Provider Fax #	

PART B: Clinical Information – Please Print

Diagnosis: ______________________________

ICD-9: ____________

Lab Results/Current Treatments:

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PART C: Treatment Plan

MEDICATION	DOSE/FREQUENCY	ROUTE	QUANTITY	# REFILLS REQUESTED

☐ New **OR** ☐ Continued prescription

Starting date requested (mm/dd/yyyy): ____________________

Who is administering medication? (Please specify) ______________________________

Where is medication being delivered to? (Please specify): ______________________________

PART D: Codes

HCPCS code(s): **(REQUIRED):** ______________________________

NDC code(s) **(REQUIRED):** ______________________________

Please fax this completed form with supporting clinical documentation and/or other relevant data to:

TriWest Healthcare Alliance – Fax: 866-269-5892

TRICARE Prime Remote, TRICARE Reserve Select – Fax: 866-312-5831

This data will be used in making a final determination.

Note: HIPAA authorization requirements do not apply to protected information used for treatment, payment, or health care operations including medical records requested for the provision of health care services.
Privacy Act Statement: This information is protected under the Privacy Act of 1974 and shall be handled as “for official use only.” Violations of this may be punishable by fines, imprisonment, or both.