TASB Risk Management Fund
P.O. Box 2010 • Austin, Texas 78768-2010 • 800.482.7276
12007 Research Blvd. • Austin, Texas 78759-2439 • tasbrmf.org
Administered by the Texas Association of School Boards

WORKER'S COMPENSATION PREAUTHORIZATION REQUEST FOR PRESCRIPTION DRUG BENEFITS

FAX COMPLETED FORM TO 888-777-8272

Date	Claimant Name	Date of Birth
Address		Date of Injury
Employer	Claim#	First Responder (Fire, Police, EMS) ☐ Yes ☐ No

REQUESTING PROVIDER OR FACILITY		
Name	Phone	Fax
Contact Name	NPI Number	Tax ID
Address	City	State/Zip Code

ORDERING PHYSICIAN		PLACE OF SERVICE	
Name		Name	
NPI	Tax ID	NPI	Tax ID
Phone	Fax	Phone	Fax
Address		Address	

PRESCRIPTION DRUG INFORMATION
(For all **compound** drug(s), identify all ingredients below.)

Requested Drug Name:

Strength:	Route of Administration:	Quantity:	Days' Supply:	Expected Therapy Duration:

To the best of your knowledge this medication is:

☐ New Therapy ☐ Continuation of therapy (approximate date therapy initiated:

For Provider Administered Drugs Only:
HCPCS Code: NDC#: Dose Per Administration:

Compound Drug Name:

Ingredient	NDC#	Quantity	Ingredient	NDC#	Quantity

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PRESCRIPTION DEVICE INFORMATION		
Requested Device Name	Expected Duration of Use:	HCPCS Code (If applicable):

PATIENT CLINICAL INFORMATION		
Patient's diagnosis related to this request:	ICD Version:	ICD Code:

(Provide the following information to the best of your knowledge)

Drugs patient has taken for this diagnosis:

Drug Name	Strength	Frequency	Dates Started and Stopped or Approximate Duration	Describe Response, Reason for Failure, or Allergy

Drug Allergies:	Height (if applicable):	Weight (if applicable):

Relevant laboratory values and dates (attach or list below):

Date	Test	Value

ATTACH CLINICAL DOCUMENTATION AND PHYSICIAN SIGNED ORDERS

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