DEFINITIVE/PRESUMPTIVE DRUG TESTING PRIOR AUTHORIZATION FORM

Date: ____________________

Member Name: ____________________ Date of Birth: __________

Member ID#: ____________________

Provider: ____________________ Tax ID#: __________

Laboratory Completing Request: ____________________

Laboratory Tax ID#: ____________________

What phase of treatment is the patient currently in?

☐ Initiation (0 – 8 weeks) ☐ Stabilization (9 – 16 weeks) ☐ Maintenance (16 + weeks)

Requested Code	Code Description	Presumptive Result and Date	Expected Result	Result Disputed by Patient	Treatment Impact
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

If requesting testing for more substances than patient disputed the results of, please provide specific substances that you wish to be tested and rationale for testing additional substances.

Substance	Rationale

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