NWPS
NORTHWEST PHARMACY SERVICES

STEP THERAPY

CONFIDENTIAL PHYSICIAN FAX FORM

FAX TO SECURE FAX #: 360 802-5116

TODAY'S DATE: _____

PATIENT INFORMATION

Patient Name: _____

Patient DOB: _____ Insurance ID Number: _____

PHYSICIAN INFORMATION

Physician Name: _____ NPI: _____

Physician Phone: _____ Physician FAX: _____

Office Contact: _____ Phone: _____

DIAGNOSIS – ICD-9 code plus description:

_____

Medication Requested: _____

Please list all reasons for selecting the requested medication over alternatives (e.g. contraindications, allergies, history of adverse drug reactions to alternatives): _____

_____

_____

Please list the medications the patient has **previously tried and failed for treatment of this diagnosis:**

_____ Date: _____

_____ Date: _____

_____ Date: _____

Thank you.

NWPS USE ONLY: Approved: ☐ Yes ☐ No Date: _____