

SIHO Prescription Drug Medical Necessity/Prior Authorization Form

Please complete and fax to:
Columbus: 812-378-7054

Patient Name _____
SIHO ID # _____ DOB ____/____/____
Length of Treatment: Start date ____/____/____ End date ____/____/____

ORAL CONTRACEPTIVES
Prescribed medication _____
Diagnosis _____ Diagnosis Code _____

VASCULOGENICS (Viagra, Muse, Edex, etc.)
Prescribed medication _____
Diagnosis _____ Diagnosis Code _____

RETINOIDS
Prescribed medication _____
Diagnosis _____ Diagnosis Code _____

OTHER
Prescribed medication _____
Diagnosis _____ Diagnosis Code _____

The prescribed medication is medically necessary in treating the diagnosis listed above.

Prescribing Physician Signature Prescribing Physician Name (please print)
Physician phone # _____

For SIHO internal use:
SIF# _____ MDS _____ HSD _____ MSD _____
Additional information: _____

Please include any clinical information to justify this request.