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: _____*