

# Parkinson's Disease (Requip XL/ Mirapex ER)



An Independent Licensee of the Blue Cross and Blue Shield Association

## Prior Authorization Request (Physician to Complete)

Visit [www.wellmark.com](http://www.wellmark.com) for the Wellmark Drug List for current medication tier levels and updated PA Forms

### Facsimile Transmittal Sheet

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

To: Wellmark Pharmacy Services

From (Prescriber's Name): \_\_\_\_\_

Fax Number: (866) 884-4345

Prescriber's DEA Number: \_\_\_\_\_

Phone Number: (800) 600-8065

Prescriber's Phone Number: \_\_\_\_\_

Prescriber's Specialty: \_\_\_\_\_

Prescriber's Fax Number: \_\_\_\_\_

Prescriber's Office Address: \_\_\_\_\_

Street

Suite #

City

State

Zip

Patient Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_ Patient DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

1. Please provide the diagnosis this therapy has been prescribed for: \_\_\_\_\_  
\_\_\_\_\_

ICD-9 Code: \_\_\_\_\_

2. Which drug are you requesting?

Requip XL

Mirapex ER

3. Drug Strength: \_\_\_\_\_ mg      Quantity/30 days: \_\_\_\_\_ units

Directions: \_\_\_\_\_

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient, you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received this fax in error, please immediately notify the sender by telephone and destroy this original fax message.