VALUE OPTIONS - NORTHSTAR
MEDICATION REQUEST FORM

Member's Name: _____
First Middle I. Last

Member's North Star ID Number: _____ Date of Birth: _____/_____/_____

Physician: _____ Contact Person at office: _____

Phone Number: (____) _____-_____ Fax Number: (____) _____-_____

Requested Medication: _____ Medication Allergies: _____

Relevant Diagnosis: _____
Has the member been on this medication in the past? ____Yes ____No If yes, for how long? _____

Please identify the setting the member was stabilized in if the member is currently taking this medication
_____State Hospital _____Private Practice _____Other _____

Request for Copay Waiver _____ Yes _____ No

Request for Dosage Override _____Yes _____No _____Dose Requested

Previous Medication History:

Drug Strength and Dose	Dates of Therapy	Reason for Discontinuing

Rationale for Request_____

_____

_____

_____

_____

_____

_____

Physician's Signature: _____ Date: ____/____/_____

FAX TO: (866) 247-8751