



Instructions

- The prescriber should only complete this form.
- Please fax completed form to: 866-213-6066.
- To speak to an SXC customer service representative, please call: 1-800-OHIOBWC.

Injured worker information

Request date	BWC claim number
Injured worker name	
Injured worker date of injury	

Prescriber information

Prescriber	Prescriber NPI
Prescriber phone	Prescriber fax number

Medication requested and conditions being treated (Required)

Medication name	ICD-9 code(s)	ICD-9 code description(s)
1.		
2.		
3.		
4.		

Additional information

Requested duration of authorization:

Justification for request (Required - attach separate sheet if needed.)

Please document how the medication(s) requested is/are related to the treatment of, or the control of symptoms associated with the allowed conditions in the claim.

Prescriber signature (required)	Signature date
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