ODS 95165 PREAUTHORIZATION REQUEST FORM

Date:	Date of Service:
Patient Name:	Patient DOB:
Patient ID#:	Patient Chart #:

NOTE: ***ATTACH COPIES OF ALLERGY TESTING RESULTS, DETAILED BOTTLE RECIPE ORDERS, AND/OR CHART NOTES FOR SUPPORTING INFORMATION.***

1. **Medical necessity** for more than two bottle sets and/or more than 28 doses per bottle set:
   _____

   _____

2. Using _____ (#) Bottle Sets.

   Clinical reasons for multiple bottle sets*:*

   a. _____

   b. (Incompatible antigens) _____ and _____ cannot be mixed together.

   c. (Incompatible antigens) _____ and _____ cannot be mixed together.

Expected Dosing Schedule for build phase:

Date first dose given/planned (mm/dd/yy):	
Month & Year expected to reach Maintenance phase:	

Bottle Set #1	**Contains antigens:**						
	Dilution 5	Dilution 4	Dilution 3	Dilution 2	Dilution 1	Full strength	**Total doses**
# doses:							

Bottle Set #2	**Contains antigens:**						
	Dilution 5	Dilution 4	Dilution 3	Dilution 2	Dilution 1	Full strength	**Total doses**
# doses:							

Bottle Set #3	**Contains antigens:**						
	Dilution 5	Dilution 4	Dilution 3	Dilution 2	Dilution 1	Full strength	**Total doses**
# doses:							

Bottle Set #4	**Contains antigens:**						
	Dilution 5	Dilution 4	Dilution 3	Dilution 2	Dilution 1	Full strength	**Total doses**
# doses							

GRAND TOTAL all sets combined (Total # doses requesting preauthorized):	

Physician Signature: _____

Return fax number: 503-243-5105 Attention: _____