



**Instructions**

- The prescriber should only complete this form.
- Please fax completed form to 866-213-6066.
- To speak with an SXC customer service representative, please call 877-615-6330.

**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.              |               |                           |

- ☐ Non-sterile compound   ☐ Sterile compound (pain pump)
- ☐ Brand name drug: The injured worker has a documented, systemic allergic reaction, which is consistent with known symptoms or clinical findings of a medication allergy and has tried other generic drug(s).

**Post surgical medication request**

|                           |
|---------------------------|
| Date of scheduled surgery |
|---------------------------|

**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 |
|---------------------------------|----------------|