



AUTHORIZATION FOR RESTRICTED DRUG USE

FEDS/GSA Health & Dental Plan

Name: _____ Student ID#: _____
(Please print)

Date of Birth: _____ Phone Number: (____) _____
(mm/dd/yyyy)

Diagnosis: _____

First line drug treatment: _____

Date: _____

Second line treatment: _____

Date: _____

Request for Drug on Restricted Drug Usage list:

Drug Name: _____ Drug Identification Number (DIN): _____

Reason: _____

Prescribing Physician: _____
(Please print)

Phone Number:(____) _____

For Health Services Use only:

Medical Director's Authorization: _____

Effective Date: _____