

6900



Clinical Documentation is required for a determination to be made.

Please fax completed form back to: (207) 828-7816

Step Please complete patient and physician information (please print):

1

Physician Name: _____

Address: _____

Phone #: _____

Secure Fax #: _____

Step Please complete the clinical assessment:

2

1. **Provider acknowledges other strengths and formulations of potassium chloride are available without prior authorization.**

☐ Acknowledged

Proceed to question 2

- 2. Please explain why the patient requires Pokonza and cannot take the cost-effective generic potassium chloride formulations.**

Sign and date below

Step I certify the above is true to the best of my knowledge. Please sign and date:

3

Prescriber Signature

Date _____

[26 June 2024]