



Please complete ALL information below and fax your request to 1-888-671-5285

Formulary Exception Prior Authorization Request Form (Page 1 of 2)

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| Member Information <small>(required)</small> | | | Provider Information <small>(required)</small> | | |
|--|--------|------|--|--------|--------------|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | | Specialty: |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |
| Medication Information <small>(required)</small> | | | | | |
| Medication Name: | | | Strength: | | Dosage Form: |
| <input type="checkbox"/> Check if generic substitution is acceptable | | | Directions for Use: | | |
| <input type="checkbox"/> Check if request is for continuation of therapy | | | | | |
| Clinical Information <small>(required)</small> | | | | | |
| What is the patient's diagnosis for the medication being requested (specify all)? | | | | | |
| _____ | | | | | |
| ICD-10 Code(s): _____ | | | | | |
| NON-FORMULARY EXCEPTIONS [coverage at the highest level of cost-share] | | | | | |
| Has the patient had an inadequate response or inability to tolerate three preferred or generic formulary alternatives in the same drug class? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| *If yes , specify all alternatives: _____ | | | | | |
| NON- PREFERRED DRUG TIER EXCEPTION REQUESTS [Brand medication to preferred brand tier or Non-Preferred Generic to generic tier] | | | | | |
| Has the patient had an inadequate response or inability to tolerate three preferred or generic formulary alternatives in the same drug class? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| *If yes , specify all alternatives: _____ | | | | | |
| CHIP [CHILDREN'S HEALTH INSURANCE PROGRAM) TIER EXCEPTION REQUESTS | | | | | |
| Has the patient had an inadequate response or inability to tolerate at least three generic alternatives in the same drug class? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| *If yes , specify all alternatives: _____ | | | | | |
| NON-PREFERRED COMPOUNDED PRODUCT TIER EXCEPTION | | | | | |
| Has a prior authorization been approved for this compound? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Has the patient had an inadequate response or inability to tolerate all other formulary alternatives for the requested diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| *If yes , specify all alternatives: _____ | | | | | |
| NO COST-SHARE EXCEPTION: | | | | | |
| Is the drug described as either a preventative medication by US Preventative Services Task Force (USPSTF) or Women's Preventative Services provision of the Patient Protection and Affordable Care Act (PPACA)? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Has patient had an inadequate response or inability to tolerate the generic equivalent for the brand drug requested (if available)? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Has the patient had an inadequate response or inability to tolerate a generic prescription alternative for the brand drug requested? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| *If yes , specify all alternatives: _____ | | | | | |

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.