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

Select Formulary Exception Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
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 (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

What is the patient's diagnosis for the medication being requested (specify all)?

_____

ICD-10 Code(s): _____

Is the requested medication being used to treat the patient's stage four, advanced metastatic cancer or a severe adverse health condition experienced as a result of stage four, advanced metastatic cancer? ❑ Yes ❑ No

NON-PREFERRED DRUG TIER EXCEPTION REQUESTS [Brand medication (or authorized generic) to preferred brand tier or Non-Preferred Generic to generic tier]

Has the patient had an inadequate response or inability to tolerate at least three preferred or generic tier alternatives in the same pharmacological class? ❑ **Yes** ❑ **No**

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 pharmacological class? ❑ **Yes** ❑ **No**

Specify all alternatives: _____

NON-PREFERRED COMPOUNDED PRODUCT TIER EXCEPTION

Has a prior authorization been approved for this compound? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response or inability to tolerate/use all other formulary alternatives? ❑ **Yes** ❑ **No**

Specify all alternatives: _____

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.