

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:
<input type="checkbox"/> Check if <b>generic substitution</b> is acceptable		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

### 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.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of the Pharmacy Benefit Manager. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: FormularyException\_FS\_2021Mar