# PHARMACY Medication Prior Authorization / Exception Request Form

**FAX: 1-855-720-5825**
**Phone: 877-358-8797**

**To ensure a timely response, please fill out the form completely and legibly.**

**Decisions are made within 24 hours of receipt of all necessary medical documentation.**

| Member Name Last, First) | Member ID# | DOB | Date |
|---|---|---|---|
| Requesting Provider Name | NPI: | PCP ( if different) | |
| Office Contact Person | Direct Phone # | Fax # | |
| Diagnosis 1 (include ICD-9) | Diagnosis 2 | Diagnosis 3 | |

**Please send all pertinent clinical documentation with this fax.**

**Use of pharmaceutical samples cannot be accepted as justification.**

| Name of Medication (and J-code If applicable) | Dosage | Quantity/ Amount | Refills (<12) |
|---|---|---|---|
| Sig/Instructions | Allergies | | |
| List Formulary Medications Tried include length of treatment and response with dates | | | |
| List Formulary Medications Contraindicated / Reason | | | |

☐ This is a reauthorization of current medication. Recent clinical documentation is required. Please provide.

**CONFIDENTIALITY NOTICE**: This fax transmission, including any attachments, contains confidential information that may be privileged. The information is intended only for the use of the individual(s) or entity to which it is addressed. If you are not the intended recipient, any disclosure, distribution or the taking of any action in reliance upon this fax transmission is prohibited and may be unlawful. If you have received this fax in error, please notify the sender immediately via telephone at the above phone number and destroy the original documents. Thank you.

Date Revised: June 13