Medicare Part D
Formulary Exception/Prior Authorization Request Form
Please Fax to: (866) 855-2676

☐ Standard Request (72 hours)

☐ Expedited Request (24 hours – must be critical to patient care)

Date of Request: _____

Physician's Name: _____

Physician's DEA#: _____ Specialty: _____

Phone # : _____ Fax # : _____

Patient's Name: _____ DOB: _____ Gender: _____

Patient's ID# : _____ Patient's Diagnosis : _____

Medication Needed: _____ Strength: _____

Quantity: _____ Directions: _____ Duration: _____

Has this patient tried other medications for this condition? (List drug, duration, results)

_____

_____

_____

Clinical rationale for selected drug usage: _____

_____

_____

_____

Is patient currently taking drug? _____ If so, how long? _____

*** All fields must be complete and legible for Review***

*** Only one medication request per form***