



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***

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