



Non-Formulary Exception Request

Attempt:
 First _____ Second _____ Final _____

Reason for PA:
 Strength/Dosage Change Exceeds plan limits
 Step Therapy Brand Only PA required

PA Status:
 Pending Supporting Records
 Approved: PA# _____
 Denied: Reason _____

Drug Requested _____ **Strength** _____ **Qty** _____
 (one drug per form only)

Date: _____ Plan: _____ Patient ID#: _____ DOB: _____

Patient Name: _____ Provider NPI: _____

Prescribing Physician: _____ Office Contact: _____

Office Fax #: _____ Office Phone: _____

1. PROVIDER SPECIALTY (specify all) _____

2. DIAGNOSIS FOR DRUG REQUESTED (specify all) _____

3. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

N/A If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration

The most recent supporting medical/rx records need to be attached to PA form. Most common item faxed in include the doctor visit notes. Please be sure what is sent in covers diagnosis and drug requested.