RxPreferred

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. Prescribing Physician Signature: _____

4. 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

<u>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.</u>

<u>FAX TO (888) 631-0862</u> PHONE (888) 666-7271