RX PREFERRED BENEFITS

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

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.

FAX TO (888) 631-0862 PHONE (888) 666-7271