



Pharmacy Part D Prior Authorization/Exception Request Form

Fax completed form to: 330-363-2350 or mail to: P.O. Box 6905 Canton, Ohio 44706
Call with any questions: 330-363-7407 and ask for Utilization Management. If faxing after hours, please call and notify on-call nurse of the time request was faxed.

Patient Name _____ DOB _____
SS#/ID # _____ GRP# _____

Request is for (circle one): Prior Auth Tier exception
Limit exception Non-formulary exception

Requested Medication _____
(Please include name, strength, quantity and route. For IV medications please include stop date.)

Diagnosis/Rationale for Request: _____

Names of previous medications tried for this condition and reasons of therapeutic failure:

Physician: _____ Office Contact: _____

Phone: _____ Fax: _____

Physician Signature: _____

Date Faxed: _____ Time Faxed: _____

[] Approved [] Denied

Rationale for Decision: _____

Nurses Signature: _____ Date: _____ Time: _____

Implementation Date: February 06, 2006
Review Date(s):
Revision Date(s): March 14, 2006
UM Committee Approval Date(s):