



RxAmerica
 221 N. Charles Lindbergh Dr.
 Salt Lake City, UT 84122-9902
 Fax: 1.866.855.2676

Medicare Part D Formulary Exception/Prior Authorization Form

This form cannot be used to request Medicare non-covered drugs, including barbiturates, benzodiazepines, fertility drugs, drugs prescribed for weight loss, weight gain or hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations). Biotech or other specialty drugs for which drug-specific forms are required. See www.Meds4Medicare.com

• Only one medication request per form •• All fields must be complete and legible for review ••

<input type="checkbox"/> STANDARD REVIEW [72 HOURS]			<input type="checkbox"/> EXPEDITED REVIEW [24 HOURS]		
By selecting the expedited review and signing this form below, I certify that applying the 72-hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.					
PATIENT INFORMATION			PRESCRIBER INFORMATION		
Patient Name:			Prescriber Name and Specialty:		
Member ID#:			NPI/DEA#:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Sex (circle):	M	F	Date of Birth:	Office Phone:	Office Fax:
Patient Phone:			Contact Person:		
Pharmacy Name:			Pharmacy Fax:		
DIAGNOSIS AND MEDICAL INFORMATION					
Medication:		Strength and Route of Admission:		Frequency:	
<input type="checkbox"/> New Prescription -OR- Date Therapy Initiated: / /		Expected Length of Therapy:		Quantity:	
Height and Weight:		Drug Allergies:		Diagnosis Related to Medication Requested (ICD9):	
RATIONALE FOR EXCEPTION REQUEST OR PRIOR AUTHORIZATION					
<input type="checkbox"/> List alternate drug(s) contraindicated or previously tried, but with adverse outcome(s) (e.g. toxicity, allergy, or therapeutic failure): (1) Drug(s) tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s); (1) _____ (2) _____ (3) _____ (1) _____ (2) _____ (3) _____ (1) _____ (2) _____ (3) _____					
In order to complete the review process, please include chart notes documenting trial and failure on the above medications					
<input type="checkbox"/> Complex patient with two or more chronic conditions is stable on current drug(s); high risk of significant adverse clinical outcome with medication change. Specify below the anticipated significant adverse clinical outcome: _____ _____					
<input type="checkbox"/> Medical need for different dosage from and/or higher dosage - Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason _____ _____					
<input type="checkbox"/> Pertinent Laboratory Tests and Results: (Attach copies of results)					
<input type="checkbox"/> Request for formulary tier exception					
Prescriber's Signature:					Date:

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