



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:

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (Via return FAX) immediately and arrange for the return or destruction of these documents.

H6178_OHMSNP208