|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Member Information (required)** | | | **Prescriber Information (required)** | | | | |
| Member Name: | | | Prescriber Name: | | | | |
| Member/Insurance ID: | | | NPI: | | | | |
| Date of Birth: | | | Office Phone: | | | | |
| Street Address: | | | Office Fax: | | | | |
| City: | State: | Zip: | Office Street Address: | | | | |
| Phone: | | | City: | State: | | | Zip: |
| **Medication Information (required)** | | | | | | | |
| Medication Name: | | | Strength: | | | Dosage Form: | |
| Check if requesting **brand** | | | Directions for Use: | | | | |
| Check if request is for **continuation of therapy** | | | Qty: | | DS: | | |
| Check if request is **urgent** | | | Check to request **priority review** | | | | |
| **Clinical Information (required)** | | | | | | | |
| What is the patient’s diagnosis?  ICD-10 Code(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| Is the request for initial or continuing therapy?  **Initial Therapy  Continuing Therapy** | | | | | | | |
| **INITIAL THERAPY** | | | | | | | |
| What medication(s) has the patient tried and failed? Please include medication names, dates of therapy (MM/YY), and patient’s response to therapy | | | | | | | |
| **CONTINUING THERAPY** | | | | | | | |
| Is the patient responding to the current therapy and experiencing benefit (e.g., improvement in symptoms, improvement in QOL, etc.)?  **Yes  No**  Date patient started therapy (MM/YY): ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| **QTY LIMIT REQUESTS**  What is the quantity requested per DAY? \_\_\_\_\_\_\_  What is the reason for exceeding the plan limitations? **Select all that apply –**  Titration or loading dose purposes (please include specific titration/loading dose schedule and anticipate duration)  Dose-alternating schedule  Requested strength/dose is not commercially available  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |

**Are there other comments or information the prescriber wishes to provide for this review?**

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**Please note:**  Recent chart notes discussing the patient’s diagnosis AND all pertinent lab values or medical tests should be included for review.

This request may be denied unless all required information is received.

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