

# PRIOR AUTHORIZATION/DRUG EXCEPTION REQUEST FORM

**PLEASE ALLOW 24 HOURS TO PROCESS**

## INSTRUCTIONS:

- PLEASE FAX THE COMPLETED PRIOR AUTHORIZATION/NON-FORMULARY REQUEST TO PHARMACY DEPARTMENT: FAX: (813) 506-6152
- NOTE: ANY MEMBER OF THE PHYSICIAN'S STAFF MAY COMMUNICATE THIS INFORMATION TO FREEDOM HEALTH PLAN. EXPEDITED REQUEST CALL: PHONE: (888) 796-0946

## PATIENT INFORMATION

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

FREEDOM PATIENT ID NUMBER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PHARMACY: \_\_\_\_\_ PHARMACY PHONE: \_\_\_\_\_

## DRUG REQUESTED

NAME: \_\_\_\_\_ STRENGTH: \_\_\_\_\_ QUANTITY: \_\_\_\_\_ DURATION: \_\_\_\_\_

1. HAS THIS PATIENT PREVIOUSLY RECEIVED THIS DRUG?  YES  NO

IF YES, HOW LONG HAS PATIENT BEEN ON THIS DRUG? \_\_\_\_\_

2. HAS PATIENT HAD A DOCUMENTED ALLERGY/INTOLERANCE TO THE FORMULARY MEDICATION?

YES  NO  N/A

3. LIST THERAPY FAILURE ON ONE OR MORE FORMULARY DRUGS WITHIN THE SAME THERAPEUTIC CLASS: \_\_\_\_\_

4. PATIENT DIAGNOSIS: \_\_\_\_\_

5. MEDICAL RATIONALE: (Please send all medical documentation/notes to support request. Failure to submit documentation could delay process. ) \_\_\_\_\_

PHYSICIAN NAME: \_\_\_\_\_ PHYSICIAN PHONE #: \_\_\_\_\_

SPECIALTY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE: \_\_\_\_\_

PHYSICIAN FAX: # (FOR FAXED NOTIFICATION): \_\_\_\_\_

OFFICE CONTACT: \_\_\_\_\_

### FOR FREEDOM USE ONLY

Approved \_\_\_\_\_ Denied \_\_\_\_\_ More Information Needed \_\_\_\_\_ Approved as Modified \_\_\_\_\_ Pt. not Eligible \_\_\_\_\_

COMMENTS: \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

Valid for \_\_\_\_\_ Expires \_\_\_\_\_