

# FREEDOM HEALTH PLAN MEDICATION THERAPY REVIEW

## INSTRUCTIONS:

- PLEASE FAX THE COMPLETED PRIOR AUTHORIZATION/STEP THERAPY REQUEST TO PHARMACY DEPARTMENT: FAX: (727) 451-6820
- NOTE: ANY MEMBER OF THE PHYSICIAN'S STAFF MAY COMMUNICATE THIS INFORMATION TO FREEDOM HEALTH PLAN. EXPEDITED REQUEST CALL: PHONE: (888) 407-9977

## PATIENT INFORMATION

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

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

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

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

## DRUG REQUESTED

NAME: \_\_\_\_\_ STRENGTH: \_\_\_\_\_ QUANTITY: \_\_\_\_\_ DURATION OF THERAPY: \_\_\_\_\_

1. HAS THIS PATIENT PREVIOUSLY RECEIVED THIS DRUG?  YES  NO IF YES, HOW LONG? \_\_\_\_\_

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

2. HAS PATIENT HAD A DOCUMENTED ALLERGY/INTOLERANCE TO SIMILAR FORMULARY MEDICATIONS?

YES  NO  N/A

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

4. PATIENT DIAGNOSIS:

***Please include all relevant documentation, including the most recent tests, procedures, prior therapies tried and failed, etc., to support your request for this drug.***

**It is important that the following information is filled in completely in order to successfully process your request.**

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

FIRST: \_\_\_\_\_ LAST: \_\_\_\_\_

NPI: \_\_\_\_\_ SPECIALTY: \_\_\_\_\_ DATE: \_\_\_\_\_

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

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

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