

Please choose one: Prior Authorization/Formulary Exception Tiering Exception

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- EXPEDITED (24 hours)**
- By checking this box and signing 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.

For a list of drugs covered by our formulary, visit www.peopleshealth.com and click on the Prescription Drugs Search link.Failure to complete this form in its entirety may result in an adverse determination due to insufficient information.**Member Information**Member Name: _____ Member ID Number: _____
Date of Birth: _____**Prescriber Information**Prescriber Name: _____ Specialty: _____
Phone: _____ Fax: _____
Office Contact: _____**Medication Request**Drug Name/Strength: _____ Quantity: _____
SIG: _____ Days Supply: _____
Route of Administration: _____ Duration of Therapy: _____**Diagnosis(es) related to use** (please include ICD-9 code(s) if available): _____**Rationale for Exception Request or Prior Authorization**Check all applicable box(es) and provide the requested details in the **REQUIRED EXPLANATION** section.**FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION**

- Alternate drug(s) contraindicated or previously tried, but with adverse outcome (e.g., toxicity, allergy or therapeutic failure)
Indicate the following in the *Required Explanation* section: 1. Drug(s) contraindicated or tried; 2. Adverse outcome for each; 3. If therapeutic failure, length of therapy on each drug(s)
- Complex patient with one or more chronic conditions (e.g., psychiatric condition or diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change
Indicate the following in the *Required Explanation* section: Anticipated significant adverse clinical outcome
- Medical need for different dosage form and/or higher dosage
Indicate the following in the *Required Explanation* section: 1. Dosage form(s) and/or dosage(s) tried; 2. Medical reason for change
- Request for formulary tiering exception
Indicate the following in the *Required Explanation* section: 1. Names of formulary or preferred drugs contraindicated, **OR** tried and failed, **OR** tried and not as effective as requested drug; 2. If therapeutic failure, length of therapy on each drug and adverse outcome; 3. If not as effective, length of therapy on each drug and outcome
- Other _____

Provide an explanation in the **Required Explanation** section.**REQUIRED EXPLANATION:**_____

Prescriber Signature_____
Date

Please provide any additional pertinent information on a separate sheet(s).