Pharmacy Benefit Dimensions
An Independent Health company

REQUEST FOR A NON-FORMULARY PRIOR AUTHORIZED DRUG EXCEPTION OR STEP THERAPY

**** for internal use only ****

Member ID Number: _____ Member Name: _____

DOB: _____ Date: _____ Time: _____

Provider Stated Request is Urgent*: Yes ☐ No ☐

If yes, check the appropriate box(es) below.

My patient's health would be in serious jeopardy if required to wait for a standard coverage determination decision.

Yes ☐ No ☐

My patient would experience pain that cannot be adequately controlled if required to wait for a standard coverage determination decision. Yes ☐ No ☐

***For verbal PA/exception requests, providers are highly encouraged to submit/fax supporting office notes**

716-631-9636 OR 716-631-0149 OR 800-273-7397

Provider Name: _____ **Provider NPI: _____**

Fax Number: _____ **Phone Number: _____**

Contact Person at office and Phone number: _____ Phone Number: _____

Diagnosis / ICD-10 Code(s): _____

Drug and Strength Requested: _____

Prescription Instructions: _____

Quantity Prescribed: _____

***Reason claim is rejecting at pharmacy (mark N/A if there is not a rejected claim)*:**

Is the medication listed on the member plan's formulary? Yes ☐ No ☐

Reason(s) Prior Authorization or Exception is Requested:
(PA required, dose exception, QTY exception, lost medication, patient going on vacation, dose increase, other explanation)

Other medications tried for this condition:

Who will administer this medication? Member ☐ Provider ☐

How will the medication be obtained? Pharmacy ☐ or Office Buy and Bill El

or please specify (i.e. retail or mail order pharmacy) :

Information Documented and Verified By: _____

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Thank you for your attention to this message.