Prescription Drug Prior Authorization Request and Formulary Exception

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SANFORD HEALTH PLAN

Fax completed form and all supporting clinical information to Pharmacy Management Team at (605) 328-6813 or submit online at sanfordhealthplan.org/providerlogin.

This form is for: ☐ Formulary Exception ☐ Prior Authorization Request

Patient Information		Prescriber Information		
Patient Name:		Prescriber Name:		
Patient ID #:		Prescriber Specialty:		
DOB:		Address:		
Medication Allergies:		City:	State:	Zip:
Diagnosis		Phone:	Fax:	
Diagnosis:	ICD-10 :	Contact Person at Prescriber's Office:		

Medication Information

Medication Being Requested:	Strength:	Directions:	Quantity	Days' Supply

Expected Length of Therapy:	Requested therapy medication is: ☐ new ☐ continuation of therapy If continuation of therapy, provide start date:

Medical Rationale for Use:

Clinical Information

Please list all current and past medications and therapies the patient has tried specific to the diagnosis:

Medications/Therapies (if drug therapy, specify drug name and dose)	Dates of Therapy/ Treatment Duration	Outcome of Therapy (allergy, adverse event – specify and include severity, treatment failure, inadequate response)

Please list any medications specific to the diagnosis that are contraindicated or medically necessary to avoid (include rationale):

Other medical conditions to consider:

If request is for a formulary exception, explain why the preferred medication(s) would not meet your patient's needs.

Prescriber Signature (same as prescriber listed above): Date of Submission:

To provide required information, attach additional sheets, lab results and other supporting documentation as necessary.
Questions? Call the Pharmacy Management Department at (855) 305-5062. For TTY/TDD, call (877) 652-1844.
If you would like an interpreter, call LanguageLine Solutions at (800) 892-0675.