NON-FORMULARY MEDICATION/MEDICAL NECESSITY PRIOR AUTHORIZATION FORM			
Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Pharmacy Services. **FAX:** (888) 245-2049 If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (800) 392-1147 Monday through Friday 8:30am to 5:00pm			
PROVIDER INFORMATION			
Requesting Provider:		NPI:	
Provider Specialty:		Office Contact:	
Office Address:		Office Phone:	
		Office Fax:	
MEMBER INFORMATION			
Member Name:		DOB:	
Gateway ID:		Member weight:	Height:
REQUESTED DRUG INFORMATION			
Medication:		Strength:	
Directions:		Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No		Date Medication Initiated:	
Billing Information			
This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:____________________________			
Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other			
Place of Service Information			
Name:		NPI:	
Address:		Phone:	
MEDICAL HISTORY (Complete for ALL requests)			
Diagnosis:		ICD Code:	
Is the member currently or recently hospitalized? ☐ Yes, date of discharge: ___________________ ☐ No *You must be able to document the therapeutic failure or contraindication to formulary products for a request to be approved.*			
CURRENT or PREVIOUS THERAPY			
Medication Name	**Strength/ Frequency**	**Dates of Therapy**	**Status (Discontinued & Why/Current)**
REAUTHORIZATION			
Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No Please describe:			
SUPPORTING INFORMATION or CLINICAL RATIONALE			
Prescribing Provider Signature		Date	