ProCare Rx

NON-FORMULARY REQUEST

Date/Time of Request: Date:____________ Time:____________

PHYSICIAN CERTIFICATION NON-FORMULARY REQUEST FORM

Please fill out the following information and return to us as indicated below:

A. – Member Information:				
Patient Name:		Plan Name/PlanID:		
Patient ID:		Patient Date of Birth:		Patient Contact Phone#:
B. – Physician Information				
Physician Name:		Physician Address:		
Physician DEA #:			Physician Phone #:	Physician Fax Number:
Drug Name and Strength:	Direction (SIG):		QTY and Days Supply:	NDC#:
C. – Pharmacy Information				
Pharmacy Name:	NABP #:	Pharmacy Phone Number:		Pharmacy Fax Number:
D. – Clinical Information: Please fill out the following clinical information:				
Diagnosis/Indication				ICD-9 Code (if available)

1. Medical Justification for Formulary Exception:
   - ❑ The medication is medical necessary for this patient
   - ❑ Formulary options would be hazardous to use
   - ❑ Formulary options have been tried and have caused undesirable side effects or have been insufficiently effective
2. Duration of Treatment;___________________________________
3. Has patient taken this in the past? ☐ YES ☐ NO
4. If yes, for how long:____________________________________
5. Please list other medications attempted for this patient
   Medication:__________________________________ Reason therapy failed:______________________________
   Medication:__________________________________ Reason therapy failed:______________________________
   Medication:__________________________________ Reason therapy failed:______________________________

Authorized Medical Signature:			
Telephone #:		***Date:***	

When Completed Return To: ProCare PBM Clinical Division 3891 Commerce Parkway Miramar, FL 33025
1-800-662-0586 / Fax # 866-999-7736

Receipt Date/Time of Completed Request:_______________ FOR INTERNAL USE ONLY

Ticket Number: ___________

☐ Approved ☐ Denied ☐ Denial Recommended

(Date/Time)

Reviewed by: _____________ **Effective Date:**________________ **Member Contacted:**________________
Review Date: _____________ **Termination Date:** _____________ **MD Contacted:**____________________
Review Time: _____________ **Pharmacy Contacted:**_______________

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPPA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes. *Revised 11/2005*