

ProCare Rx

Date/Time of Request: Date: _____ Time: _____

PHYSICIAN CERTIFICATION QUANTITY OVERRIDE REQUEST FORM

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

A. - Member Information:									
Patient Name:		Plan Name/Plan ID:							
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): -----SEE BELOW-----	QTY and Days Supply: -----SEE BELOW---	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)						
<p>1. Medical Justification for <u>QUANTITY OVERRIDE REQUEST</u>:</p> <p><input type="checkbox"/> The medication is medical necessary for this patient</p> <p><input type="checkbox"/> Formulary options would be hazardous to use</p> <p><input type="checkbox"/> Formulary options have been tried and have caused undesirable side effects or have been insufficiently effective</p> <p>2. Dosing Instructions per 30day supply : _____</p> <p>3. Length of Treatment Requesting at this dose: _____</p> <p>4. Please list other medications attempted for this patient</p> <table style="width:100%; border:none;"> <tr> <td style="width:50%;">Medication: _____</td> <td style="width:50%;">Reason therapy failed: _____</td> </tr> <tr> <td>Medication: _____</td> <td>Reason therapy failed: _____</td> </tr> <tr> <td>Medication: _____</td> <td>Reason therapy failed: _____</td> </tr> </table>				Medication: _____	Reason therapy failed: _____	Medication: _____	Reason therapy failed: _____	Medication: _____	Reason therapy failed: _____
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 3090 Premiere Parkway Ste 100 Duluth, GA 30097
1-866-965-Drug (3784) / Fax # 866-999-7736

Receipt Date of Completed Request: _____		FOR INTERNAL USE ONLY	Ticket Number: _____	
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied		(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 HIPAA 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