

Ticket #: \_\_\_\_\_ Request Date: \_\_\_\_\_ Request 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/Plan ID:							
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:							
B. Physician Information									
Physician Name:		Physician Address:							
Physician DEA #:	Physician Phone #:	Physician Fax #:							
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:						
C. Pharmacy Information									
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:						
D. Clinical Information (Please fill out the following clinical information.)									
Diagnosis/Indication:		ICD-9 Code: (if available)							
<p>1. Medical justification for <u>Formulary Exception</u>:</p> <p><input type="checkbox"/> The medication is medically 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. Duration of treatment: _____</p> <p>3. Has the patient taken this in the past?    <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p>4. If yes, for how long? _____</p> <p>5. 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, 1267 Professional Parkway, Gainesville, GA 30507  
 1-866-965-Drug (3784) / Fax # 866-999-7736