



Check here for **URGENT** request: **Medical** justification for urgent request: _____

Completed by: _____ **Appeal or reconsideration of denial?** YES NO
 Direct Phone #: _____ **Has Patient Assistance Program been denied?** YES NO
Has this medication been denied by ADAP? YES NO N/A

Prescriber Information Last Name: <input type="text"/> DEA/NPI: <input type="text"/> Phone: <input type="text"/>	First Name <input type="text"/> Specialty: <input type="text"/> Fax: <input type="text"/>
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Member Information Last Name: <input type="text"/> Member ID Number: <input type="text"/>	First Name <input type="text"/> DOB: <input type="text"/>
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Medication Information: Drug Name and Strength: _____ Diagnosis: _____	Quantity and Dosing: _____ Duration: _____
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Prior Authorization Criteria: General (Non-Preferred)

You must answer ALL questions		
1. Has the patient tried/ failed an adequate trial of a preferred drug? (Document drug, dates of trials, and description of failures below) _____ _____	Y	N
2. Has the patient experienced an adverse event, or been intolerant to, a preferred drug? (Document drug, dates of trials, and description of failures below) _____ _____	Y	N
3. Is the patient currently taking the requested medication? (If yes, please describe how the medication was supplied) _____ _____	Y	N

Please note any other information pertinent to this request:
Information given on this form is accurate as of this date.

Prescriber or Authorized Signature:

Date: