

OPTIMUM HEALTHCARE
PRIOR AUTHORIZATION/DRUG EXCEPTION REQUEST FORM
PLEASE ALLOW 24 HOURS TO PROCESS

INSTRUCTIONS:

- PLEASE FAX THE COMPLETED PRIOR AUTHORIZATION/NON-FORMULARY REQUEST TO PHARMACY DEPARTMENT: FAX: **(813) 506-6152**
- NOTE: ANY MEMBER OF THE PHYSICIAN'S STAFF MAY COMMUNICATE THIS INFORMATION TO OPTIMUM HEALTHCARE PLAN. EXPEDITED REQUEST CALL: PHONE: **((888) 407-9977**

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

FREEDOM PATIENT ID NUMBER: _____

DATE OF BIRTH: _____

PHARMACY: _____ PHARMACY PHONE: _____

DRUG REQUESTED

NAME: _____ STRENGTH: _____ QUANTITY: _____ DURATION: _____

1. HAS THIS PATIENT PREVIOUSLY RECEIVED THIS DRUG? YES NO

IF YES, HOW LONG HAS PATIENT BEEN ON THIS DRUG? _____

2. HAS PATIENT HAD A DOCUMENTED ALLERGY/INTOLERANCE TO THE FORMULARY MEDICATION?
 YES NO N/A

3. LIST THERAPY FAILURE ON ONE OR MORE FORMULARY DRUGS WITHIN THE SAME THERAPEUTIC CLASS:

4. PATIENT DIAGNOSIS: _____

5. MEDICAL RATIONALE: (Please send all medical documentation/notes to support request. Failure to submit documentation could delay process.)

PHYSICIAN NAME: _____ PHYSICIAN PHONE #: _____

SPECIALTY: _____

ADDRESS: _____

DATE: _____

PHYSICIAN FAX: # (FOR FAXED NOTIFICATION): _____

OFFICE CONTACT: _____

FOR OPTIMUM USE ONLY

Approved _____ Denied _____ More Information Needed _____ Approved as Modified _____ Pt. not Eligible _____

COMMENTS: _____

Name _____ Date _____

Valid for _____ Expires _____