



**PRIOR AUTHORIZATION/MEDICAL EXCEPTION REQUEST FORM**

**INSTRUCTIONS:**

- PLEASE PHONE OR FAX THE COMPLETED PRIOR AUTHORIZATION/NON-FORMULARY REQUEST TO: PHONE: (800) 454-3730 FAX: (800)-359-5781.
- NOTE: ANY MEMBER OF THE PHYSICIAN'S STAFF MAY COMMUNICATE THIS INFORMATION TO AMERIGROUP.

**PATIENT INFORMATION:**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

AMERIGROUP PATIENT ID NUMBER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PHARMACY: \_\_\_\_\_ PHARMACY PHONE: \_\_\_\_\_

**DRUG REQUESTED:** \_\_\_\_\_

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 THIS PATIENT HAD A DOCUMENTED ALLERGY 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: \_\_\_\_\_

PHYSICIAN NAME: \_\_\_\_\_ PHYSICIAN PHONE #: \_\_\_\_\_

SPECIALTY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE: \_\_\_\_\_

PHYSICIAN FAX: # (FOR FAXED NOTIFICATION): \_\_\_\_\_

OFFICE CONTACT: \_\_\_\_\_