

**PHARMACY PRIOR AUTHORIZATION or
FORMULARY EXCEPTION REQUEST FORM**

www.phoenixhealthplan.com

Phone (602) 824-3700 or (800) 747-7997

Fax (602) 674-6652 or (888) 887-9982

<input type="checkbox"/> Routine (14 days)		<input type="checkbox"/> Expedited – Life or Limb threatening (3 working days) By checking this box, you certify that applying the 14 day standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.	
Patient Name:		ID:	DOB:
Physician/Prescriber:		Contact Person:	
		Provider Phone #:	Ext:
Specialty:		Provider Fax#:	
Pharmacy Provider:		Pharmacy Phone/Fax #:	
Requested Medication:		Medication Strength:	
Directions for use:		Requested length of therapy:	

REQUIRED INFORMATION: Statement of medical necessity and supporting documentation are required for the evaluation of your request.

Diagnosis (provide as much specific information as possible):			
Description of drug allergies, contra-indication or adverse drug reactions (ADRs) pertinent to request:			
Lab Data, History, Physical Findings (ie., other clinical information that supports the use of the non-formulary medication):			
SPECIFIC FORMULARY DRUGS TRIED AND FAILED:			
Drug	Strength	Dates and Length of Therapy	Reason for Failure: (include copy of Med Watch 3500 Form if due to an ADR)
1).			
2).			
Please do not mark below this point. For PHP use only:			Date Received: _____
<input type="checkbox"/> Approved <input type="checkbox"/> Approved with Changes <input type="checkbox"/> Denied		Medical Directors Signature:	
Denial Reason:			

Comments:

Reason Code Legend - A) Not covered by AHCCCS **B)** Service provided by RBHA _____ **C)** No Evidence of failure of formulary medications
D) Not an approved Treatment **E)** Formulary Drug has not been tried or used consistently (i.e., noncompliance) **F)** Other