

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

Formulary Exception Prior Authorization Step Therapy Tier Exception Quantity Limit Exception

 **Phoenix Health Plan**
An Affiliate of Abrazo Health Care
www.phoenixhealthplan.com

Phone (602) 824-3700 or (800) 747-7997
Fax (602) 674-6652 or (888) 887-9982

 **Abrazo Advantage Health Plan (HMO)**
An Affiliate of Abrazo Health Care
www.abrazoadvantage.com

Phone: (602) 824-3900 or (888) 864 -1114
Fax: (602) 674-6652 or (888) 887-9982

<input type="checkbox"/> Routine	<input type="checkbox"/> Expedited – Life or Limb threatening	<input type="checkbox"/> Additional documentation enclosed	
Patient Name:	ID:	DOB:	Member Effective Date:
Physician/Prescriber:		Contact person:	
		Direct phone #:	Ext:
Specialty:		Fax #:	
Pharmacy Provider:		Fax Number:	
Pharmacy Provider Phone #:		Phone #:	
Requested 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).			
For PHP/AAHP use only:			
<input type="checkbox"/> Approved		Denial Reason: _____ Medical Directors Signature: _____	
<input type="checkbox"/> Approved with Changes			
<input type="checkbox"/> Denied			
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)** Other