



**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 AMERICA'S 1ST CHOICE HEALTH PLANS. EXPEDITED REQUEST CALL: PHONE: **(888) 407-9977**

**PATIENT INFORMATION**

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

AMERICA'S 1ST CHOICE 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 AMERICA'S 1ST CHOICE USE ONLY**

Approved \_\_\_\_\_ Denied \_\_\_\_\_ More Information Needed \_\_\_\_\_ Approved as Modified \_\_\_\_\_ Pt. not Eligible \_\_\_\_\_

COMMENTS: \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

Valid for \_\_\_\_\_ Expires \_\_\_\_\_