



2715 Jorie Boulevard, Suite 200, Oak Brook, IL 60523

Formulary Exception Prior Authorization Form

Complete and fax to: Hospitality Rx (877) 245-0875 For Questions Call (844) 484-4726

For more benefit information, visit www.hospitalityrx.org

1. MEMBER INFORMATION

First Name		Last Name	
Plan			
Member ID		Date of Birth	

2. DRUG INFORMATION (REQUIRED)

Drug Name and Strength			
Quantity		ICD-10	
Directions		Duration of Therapy	
EOC ID			

3. REASON FOR EXCEPTION REQUEST: FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION AND PROVIDER SIGNATURE*****

NOTE: Medication samples/coupons/discount cards are excluded from consideration as a trial

<p>Q1. Does the patient have FDA approved indication for the requesting medication?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q2. Is the patient currently treated with the requested medication?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q3. If yes, when was treatment with the requested medication started?</p> <p>_____</p>
<p>Q4. Is the patient at high risk of significant adverse clinical outcome if discontinued? (please explain)</p> <p>_____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. Please list all reasons for selecting the requested medication over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.)</p> <p>_____</p> <p>_____</p>
<p>Q6. Please list all other medications the patient is currently taking for treatment of this diagnosis.</p> <p>_____</p> <p>_____</p>
<p>Q7. Have you listed all the medications patient has tried and failed for the treatment of this diagnosis? (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products.) (documentation required)</p>

Yes

 No

Drug History: (for treatment of the condition(S) requiring the requested drug)

Drug Tried	Dates of Drug Trial	Results of previous drug trials Failure vs intolerance (Explain)

4. PHYSICIAN INFORMATION

Physician Signature		Date	
Physician Name		NPI #	
Phone Number		Fax Number	
Action Needed	<p>Only mark urgent when you are certifying that applying the 72-hour standard review timeframe would jeopardize the patient's life or health, or if the patient is in severe pain.</p> <p><input type="checkbox"/> Urgent* <input type="checkbox"/> For Review</p>	Pharmacy Name, Fax, and phone number	-----
Prescription	<p><input type="checkbox"/> New prescription <input type="checkbox"/> Renewal</p>	Contact person Name, Phone, Fax	-----

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