Hospitality Rx
711 N. Commons Dr. Aurora, IL 60504

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

Q1. Does the patient have FDA approved indication for the requesting medication?

☐ Yes ☐ No

Q2. Is the patient currently treated with the requested medication?

☐ Yes ☐ No

Q3. If yes, when was treatment with the requested medication started?

Q4. Is the patient at high risk of significant adverse clinical outcome if discontinued? (please explain)

_____

☐ Yes ☐ No

Q5. Please list all reasons for selecting the requested medication over alternatives (e.g. contraindications, allergies or history of adverse drug reactions to alternatives.)

_____

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Q6. Please list all other medications the patient is currently taking for treatment of this diagnosis.

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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)

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☐ 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 **Prescription**	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. ☐ Urgent* ☐ For Review ☐ New prescription ☐ Renewal	**Pharmacy Name, Fax, and phone number** ---------- **Contact person Name, Phone, Fax**	----------