PHARMACY PRIOR AUTHORIZATION AND NON-FORMULARY REQUEST

Date:___________________ **Type of Request:** ☐ Standard ☐ Expedited

Medical Information

Requested Medication:____

Dosing Regimen:____

Quantity:____

Duration of Therapy:____

Diagnosis Pertaining to Requested Medication:___________________________

____

Reason for Exception Request:___________________________________

____

____

Alternative Medications Tried and Reason(s) for Failure:__________________

____

Member Information

Insurance Plan:
- ☐ Healthcare Group
- ☐ University Family Care
- ☐ Maricopa Health Plan
- ☐ University Physicians Care Advantage
- ☐ Maricopa Care Advantage

Member Name:____

Insurance ID#:____

Date of Birth:____

Phone #:____

Provider Information

Provider/Attending Name:___________________________________

Phone #:____

Fax #:____

University Physicians Health Plans Office Use Only

Please fax this completed form to 866-349-0338

(2/08)