AULTCARE

Phone: 330-363-6360 **Managed Formulary**
Fax: 330-363-3284 **Exception Enrollment Form**

PATIENT INFORMATION			
Patient Name	☐ Male ☐ Female	Allergies ☐ NKDA	
Date of Birth	SSN#	Weight _____ ☐ lb ☐ kg Date	
Address	City	State	Zip
Phone # (Home)	(Work)	Email address (optional)	

INSURANCE INFORMATION		
Primary Insurance		Policyholder
Group #	Policy #	Phone #

Service Is: ☐ Routine/Non-Urgent ☐ Expedited/Urgent*

*Definition of Expedited/Urgent service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside this definition should be submitted as routine/non-urgent.

MEDICAL INFORMATION (PLEASE ANSWER ALL QUESTIONS TO PREVENT A DELAY IN PATIENT'S THERAPY.)

1. What is the patient's diagnosis? _____
2. Is the requested medication a brand name product that has an AB rated generic equivalent? ☐ yes ☐ no
   If yes, Has patient tried a > 30 day supply of the generic for the brand medication requested in the last 365 days?
   ☐ yes ☐ no
   If no, Does the patient have documented reason for failure for not trying the generic?
   ☐ yes ☐ no please explain _____
   _____
3. Has the member tried/failed or contraindicated to other therapies in the medication class? Must be documented in patients chart. ☐ yes ☐ no

If yes, please list medications and dates of therapy: _____

_____

_____

_____

4. Did the member experience or likely to experience adverse effects for alternative therapy? ☐ yes ☐ no

If yes, please give detailed explanation and clinical rationales_____

_____

_____

AULTCARE

Phone: 330-363-6360 **Managed Formulary**
Fax: 330-363-3284 **Exception Enrollment Form**

PRESCRIPTION INFORMATION				
Requested Medication	Dose	Directions	Quantity	Refills

PHYSICIAN CONTACT INFORMATION & AUTHORIZATION		
Physician Name	Office Contact	Institution
Phone	Fax	Specialty
Address	City/State/Zip	

Physician's Signature _____ **Date** _____