AULTCARE AULTRA

MANAGED FORMULARY EXCEPTION ENROLLMENT FORM

PATIENT INFORMATION

Patient Name	☐ Male ☐ Female	Allergies	☐ NKDA
Date of Birth	SSN#	Weight ☐ lb ☐ kg	Date
Address	City	State	Zip Code
Home Phone Number	Work Phone Number	Email Address	

INSURANCE INFORMATION

Primary Insurance		Policy Holder
Group Number	Policy Number	Phone Number

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.)

What is the patient's diagnosis?

Is the requested medication a brand name product that has an AB rated generic equivalent? ☐ YES ☐ NO

If yes, has the 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 to generic? ☐ YES ☐ NO

If yes, please explain:

Has the member tried/failed or contraindicated to other therapies in the medication class? (must be documented in the patient's chart) ☐ YES ☐ NO

If yes, please list medications and dates of therapy.

Did the member experience or is likely to experience adverse effects for alternative therapy? ☐ YES ☐ NO

If yes, please give a detailed explanation and clinical rationales.

PRESCRIPTION INFORMATION				
Requested Medication	Dose	Directions	Quantity	Refills

PHYSICIAN CONTACT INFORMATION AND AUTHORIZATION			
Physician Name	Office Contact	Institution	
Phone Number	Fax Number	Specialty	
Address	City	State	Zip Code
Physician Signature		Date	

Please submit the completed form via fax at 330-363-3284