



**Cleveland Clinic EHP Total Care Pharmacy Coordination
Prior Authorization/Formulary Exception Form**

Please complete this form and return via fax: 216-643-7378.
If you have any questions, please call 1-888-248-6648, option 4 or 216-986-1050, option 4.

Patient Name: _____

Patient EHP Insurance ID Number: _____ Patient DOB: _____

Requesting Physician's Name: _____

Office Phone Number: _____ Office Fax Number: _____

Requesting Physician's Signature: _____ Date: _____

Requesting Medication: _____

Strength: _____ Quantity: _____ Dosage Regimen: _____

Diagnosis: _____

Formulary Agents Tried by the Patient:

Drug & Strength	Dosing Regimen	Date Used (Approximate)	Documentation of Treatment Failure

Please Note: Completion of this form does not guarantee approval. Requests are reviewed on all available information. Decisions are generally made within two business days, but may take longer pending clinical review. Decision letters will be sent via fax to the requesting provider and to the patient via U.S. mail.

Internal Use Only: DO NOT WRITE BELOW LINE

Approved: _____ Denied: _____ Reviewer's Initials: _____ Date: _____

Medical Director's Signature: _____ Date: _____