Cleveland Clinic Employee Health Plan

Prior Authorization/Formulary Exception Form

Please indicate the answers to the following questions and then return this form by fax to 216-643-7378. If you have any questions or would like to ask for an expedited request, please call 216-986-1050 or toll-free at 1-888-246-6648.

1. Patient Name: ________________ EHP ID No.: ________ DOB: ________

2. Requested drug name and strength: ________________

3. Diagnosis associated with requested drug: ________________

____

4. Formulary agents tried by the patient:

Drug and Strength	Dates Used (approximate)	Documentation of Treatment Failure

5. Medical rationale for use of the requested drug: ________________

____

____

____

6. Physician Name *(please print)*: ________________

Phone No.: ________________ Fax No.: ________________

Physician Signature: ________________ Date: ________

7. ***For Internal Use Only***

Date Received: ________ Date Reviewed: ________ Reviewer's Initials: ________

Approved: ______ Denied: ______ Reason: ________________

____

Physician Signature: ________________ Date: ________