



DRUG PRIOR JUSTIFICATION FORM

<p>DATE OF REQUEST: _____</p> <p><u>MEMBER INFORMATION</u></p> <p>NAME _____</p> <p>MEMBER ID _____</p> <p>BIRTHDATE _____</p> <p><input type="checkbox"/> MALE</p> <p><input type="checkbox"/> FEMALE</p>	<p><u>PROVIDER INFORMATION</u></p> <p>ATTENDING PHYSICIAN: _____</p> <p>TELEPHONE NUMBER: _____</p> <p>FAX NUMBER: _____</p> <p>GROUP NAME: _____</p> <p>ATTENDING MD SIGNATURE: _____</p> <p><input checked="" type="checkbox"/> PLEASE NOTE: ALL CHART NOTES/LAB REPORTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED BEFORE A REVIEW CAN BEGIN. <u>REQUESTS SUBMITTED WITHOUT THIS DOCUMENTATION WILL BE DENIED.</u></p>
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Drug Requested: _____ Dose/frequency: _____

Initial Request Extension Request Quantity Limit Overage Request

Diagnosis & ICD-9 code _____

Additional information: _____

Please provide chart notes identifying:

- All other drugs that have been tried to treat the disease
- Outcome for each previous drug trial
- Expected duration of requested treatment
- All other pertinent information

FAX THIS REQUEST ALONG WITH SUPPORTING DOCUMENTATION TO:
PREFERRED CARE PHARMACY DEPARTMENT- (585) 258-8621

A list of drugs requiring prior justification is available at www.preferredcare.org.

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