



PLEASE FAX FORM BACK TO UNITED DRUGS PRIOR AUTHORIZATION DEPARTMENT AT 866-563-9220



NON-FORMULARY DRUG PRIOR AUTHORIZATION REQUEST

Please review the medication that is available on the "Cochise Health Systems" formulary at <http://www.uniteddrugs.com/PBM/Formularies.php> and indicate if a change may be made.

If the formulary medication is not acceptable, please complete the following questions and fax to United Drugs Prior Authorization Department at 866-563-9220 for review.

Date: Prescriber: Prescriber Phone Number: Prescriber Fax Number: Facility: Facility Fax Number:	Member: Member ID: Member DOB: Pharmacy Name: Pharmacy Phone Number: Pharmacy Fax Number:
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Requested Non-Formulary Medication

• **Diagnosis for the medication being prescribed** _____

• **Dosing Regimen Requested** _____

• **Has the patient received a trial of a formulary medication in the last year? If yes, please state the medication(s), date of trial, and reason for discontinuance**

Drug Strength and Dose	Dates of Therapy	Reason for Discontinuance

• **Please provide relevant lab values pertaining to the medication request (LFTS, Lipid Panels, AIC, CBC etc.)**

• **Please state a clinical reason why a formulary medication cannot be used**

• **Additional comments**

Internal Use Only

*** In order to expedite processing, please include lab reports with requests when appropriate: Culture Sensitivity, Hemoglobin A1C, Serum Creatinine, CD4, Hematocrit, WBC, etc.**

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