



**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 "QualxServ" 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.*

<b>Date:</b>	<b>Member:</b>
<b>Prescriber:</b>	<b>Member ID:</b>
Prescriber Phone Number:	<b>Member DOB:</b>
Prescriber Fax Number:	Pharmacy Name:
Facility:	Pharmacy Phone Number:
Facility Fax Number:	Pharmacy Fax Number:

**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**

<u>Drug Strength and Dose</u>	<u>Dates of Therapy</u>	<u>Reason for Discontinuance</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

• **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.**