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 "YAVAPAI COUNTY LTC" 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:	**Member:**
Prescriber:	**Member ID:**
Prescriber Phone Number:	**Member DOB:**
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**

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.***