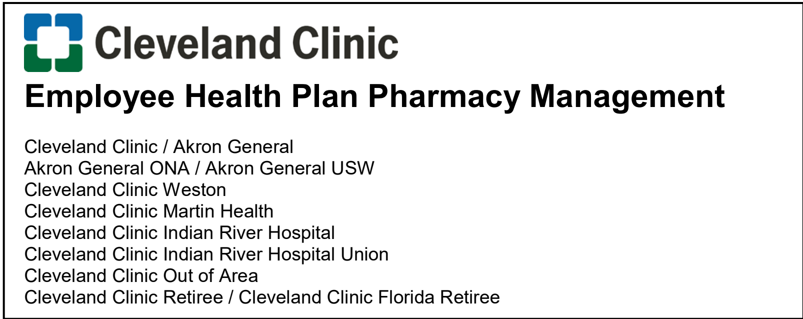
☐ **Prior Authorization**
☐ **Formulary Exception**
☐ **Appeal**



Please complete this form and return via fax: 216.442.5790

Name of Member for whom medication is being ordered:____

Member EHP Insurance ID Number: _____________________**Member DOB:** ___________________________

Requesting Physician's Name: ____

Office Phone Number: _________________________________**Office Fax Number:** ______________________

Requesting Physician's Signature: ___________________________________**Date:** _____________________

Requesting Medication:____

Strength:__________________**Quantity:**__________________**Dosage Regimen:**_________________

Diagnosis:____

Medical Rationale for Requested Medication:____

____

Formulary Agents Tried by the Member:

Drug & Strength	Dosing Regimen	Date Used (approximate)	Documentation of Treatment Failure

PLEASE NOTE: Please include any and all documentation pertaining to the request. Completion of this form does not guarantee approval. Requests are reviewed based on provided information. Decisions are generally made within two business days, but may take longer pending clinical review. Decisions letters will be sent via fax to the requesting provider and to the member via US mail.