Pharmacy Benefit Dimensions®

REQUEST FOR A NON-FORMULARY PRIOR AUTHORIZED DRUG EXCEPTION OR STEP THERAPY

Member Name: _____ **DOB:** _____

Member ID number: _____ **Date:** _____

Diagnosis: (ICD-10)_____ Is this an appeal to a previously denied request? YES or NO

(A separate request must be completed for each patient for whom the following drug is prescribed. This form does not constitute a request for addition of this drug to the drug formulary.)

Drug Requested:_____

****Required: Dose Prescribed, Dosage Form, Frequency, Quantity, and Duration of Therapy**:

_____

_____

Reason(s) Drug is Requested:_____

_____

_____

_____

Other Formulary Drugs Tried, and Results of Treatment:

_____

_____

_____

_____

I understand the above drug may not be on the current *Pharmacy Benefit Dimensions Formulary*. Further, I understand that if this request is not approved, the patient will be responsible for paying the entire cost of the medication if it is prescribed.

Requestor Signature_____ Date:_____ NPI Number: _____

Print Name:_____ **FAX #** :_____ Phone Number:_____

Contact Person (if additional information is necessary)_____

Approval does not guarantee payment; Approval is subject to the terms of the member's contract.
For questions regarding non-formulary/prior authorization requests or if the treating physician would like to discuss this case with a physician reviewer, please call the pharmacy department at (716) 250-7105 or (800) 806-8083 between the hours of 8:00 a.m. and 11:00 p.m. EST, Monday – Sunday.

If you disagree with this decision you have the right to file an expedited or standard appeal by contacting the Pharmacy department at (716) 250-7105 or 1-800-806-8083, or the member may appeal to member services at:

Pharmacy Benefit Dimensions
(716) 635-7880 or (888) 878-9172

Form may be mailed to:
Pharmacy Benefit Dimensions
Attn: Pharmacy Department
511 Farber Lakes Drive
Buffalo, NY 14221

Or faxed to:
1-866-609-1925

Confirmation to MD (Date/Time):

Fax:_____
Phone:_____
Mail:_____