

# 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 1-800-806-8083 between 7 a.m. and 11 p.m. ET, 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  
PO Box 1642  
Buffalo, NY 14231

**Or faxed to:**  
716-250-7139

Fax: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Mail: \_\_\_\_\_

**Confirmation to MD (Date/Time):**

This is a CONFIDENTIAL transmission, as it may contain information which is privileged and protected from disclosure by laws of confidentiality. The transmission is intended for the designated addressee only. If you are not the intended recipient, please contact us immediately, and REFRAIN FROM DISCLOSING OR USING THE ENCLOSED INFORMATION IN ANY WAY. Failure to comply with this direction may result in a claim that you have violated the law and are liable for money damages. Thank you for your attention to this message.

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