Formulary Exclusion Prior Authorization Form

Fax completed form to **1-312-281-1636**

ALL RELEVANT INFORMATION MUST BE COMPLETED BELOW. ALLIED'S RECEIPT OF THIS COMPLETED FORM DOES NOT CONSTITUTE A GUARANTEE OF BENEFITS.

Prescriber Information

Patient First Name: ______________________________
Patient Last Name: _______________________________
Patient ID#: _____________________________________
Patient DOB: ____________________________________
Patient Phone #: _________________________________

Patient Information

Prescriber Name: _______________________________
Prescriber DEA/NPI **(required)**: ____________________
Prescriber Phone #: _____________________________
Prescriber Fax #: _______________________________
Prescriber Address: _____________________________
State: _______________ Zip Code: _________________

Diagnosis: ____ **ICD Code:** ____

Please indicate which drug and strength is being requested: ____
Quantity Requested____________________________________**for**____**days supply**

Other Medications/Therapies tried and reason(s) for failure and/or any other information the physician feels is important to the review:
____
____
____
____
____

Prescriber Signature: ____Date: _____________________
Office Contact Name: ____________________________ Phone Number: ___________________________

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions ab out the process or required information, please contact Allied Customer Service at 1-800-288-2078. Customer Service hours are Monday – Thursday 7:30am -7:00pm central time, Friday 8:00am-5:00pm central time, and Saturday 9:00am-12:00pm central time.

Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information re garding benefits, conditions, limitations, and exclusions.

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