# Prescription Drug Prior Authorization (PA) Request or Formulary Exception Form

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TTY/TDD: (877) 652-1844
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SANFORD HEALTH PLAN

**INSTRUCTIONS:**

1. Only request one (1) medication per form.
2. All fields must be completed and legible for review.
3. **The Plan's decision will be based on individual plan policy and clinical documentation submitted.**
4. Submit online through your provider portal at sanfordhealthplan.com/providerlogin. **Prior authorizations *cannot* be completed over the phone.**
5. Questions? Contact Pharmacy Management Department at (855) 305-5062.

Please check the appropriate box below. This form is being used for:

☐ Formulary Exception ☐ Prior Authorization (PA) Request ☐ Unsure/Unknown

## Member Information

| Member Name: | Date of Birth: |
|---|---|
| Member ID #: | Drug Allergies: |

## Provider Information

| Prescriber name (first & last): | ☐ MD ☐ NP ☐ DO ☐ APRN ☐ PA ☐ _____ |
|---|---|
| Specialty: NPI #: | |
| Address: | |
| City, State, Zip: | |
| Phone: Fax: | |
| Contact person at provider's office: | |

## Billing Facility Information *(if applicable)*

| Facility Name: | |
|---|---|
| Tax ID #: NPI #: | |
| Address: | |
| City, State, Zip: | |
| Phone: Fax: | |
| Contact person at facility: | |

## Prescription Drug Information

| Medication being requested: | Strength: | Quantity: | Day's Supply: |
|---|---|---|---|
| HCPC (if applicable): | Directions for use: | | |

| Requested therapy medication is: ☐ New ☐ Continuation of therapy ** If continuation, provide start date: _____ | Expected length of therapy: | ☐ Check here if this request is for retroactive coverage for a previous claim or date of service. Date of service: _____ |
|---|---|---|

Medical rationale for use:

## Diagnosis

| PRIMARY DIAGNOSIS (ICD-10 CODE): | SECONDARY DIAGNOSIS (ICD-10 CODE): |
|---|---|
| DESCRIPTION: | DESCRIPTION: |

## Clinical Information Submitted for Determination

- The specific records needed for review must be attached. Denote below which pages of the records to review to help expedite the review process.
- If you are a Sanford Health provider and would like the Plan to review clinical documentation in One Chart (the patient's electronic medical record), the dates and descriptions of specific records to reference **must** be indicated below.

☐ Current clinical notes

☐ Labs

☐ Other

☐ Other medical conditions to consider:

☐ If the request is for a formulary exception, explain why the preferred medication(s) would not meet the Member's needs:

## Previous Therapies

- List all current and past therapies the Member has tried specific to the diagnosis.
- **NOTE:** "see chart" is not acceptable documentation for this section.

| Medications/Therapies (Drug name, strength, & dosing schedule) | Dates of Therapy/ Treatment Duration | Outcome of Therapy or Reason for Discontinuation (Describe any adverse reactions or efficacy failure) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

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## Signature

Requesting Person/Authorized Representative Signature:

Printed Name: Date Submitted: