Formulary Exception Request Form
Non-Formulary Medications

Patient Information	Prescriber Information
Member Name:	Prescriber Name:
Bravo ID #	Prescriber Specialty:
DOB:	Prescriber Address:
Address:	
	Office Phone#:
	Office Fax #:
	Contact Person:

Diagnosis and Medication Requested

Medication Requested (dosage, frequency): Qty:

Prescribing Diagnosis: ICD9 Code Date Therapy Initiated:

Rationale for Exception Request or Prior Authorization
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

Please provide rationale supporting request for coverage of non-formulary agents.

- If rationale is alternative therapy, please provide clinical documentation supporting :
  - Name of alternate therapy, dates and duration of alternate therapy and outcome of each.

REQUIRED EXPLANATION:

Failure to provide clinical documentation supporting rationale may result in this request being denied

Request for Expedited Review

☐ **REQUEST FOR EXPEDITED REVIEW [24 HOURS]**
BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Prescriber's Signature: _____ **Date:** _____

Fax back to: 866-464-0709 **For info call: 877-813-5595**
For additional Prior Authorization forms, go to http://www.bravohealth.com/providers.aspx