

FREEDOM HEALTH PLAN MEDICATION THERAPY REVIEW

INSTRUCTIONS:

- PLEASE FAX THE COMPLETED PRIOR AUTHORIZATION/STEP THERAPY REQUEST TO PHARMACY DEPARTMENT: FAX: **(1-844-430-1704)**
- NOTE: ANY MEMBER OF THE PHYSICIAN'S STAFF MAY COMMUNICATE THIS INFORMATION TO FREEDOM HEALTH PLAN. EXPEDITED REQUEST CALL: PHONE: **(1-833-272-9772)**

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

PATIENT ID NUMBER: _____

DATE OF BIRTH: _____

PHARMACY: _____ PHARMACY PHONE: _____

DRUG REQUESTED

NAME: _____ STRENGTH: _____ QUANTITY: _____ DURATION OF THERAPY: _____

1. HAS THIS PATIENT PREVIOUSLY RECEIVED THIS DRUG? YES NO IF YES, HOW LONG? _____

START DATE: _____

2. HAS PATIENT HAD A DOCUMENTED ALLERGY/INTOLERANCE TO SIMILAR FORMULARY MEDICATIONS?

YES

NO

N/A

3. LIST THERAPY FAILURE ON ONE OR MORE FORMULARY DRUGS WITHIN THE SAME THERAPEUTIC CLASS:

4. PATIENT DIAGNOSIS:

Please include all relevant documentation, including the most recent tests, procedures, prior therapies tried and failed, etc., to support your request for this drug.

It is important that the following information is filled in completely in order to successfully process your request.

PHYSICIAN NAME: _____ PHYSICIAN PHONE # _____

FIRST: _____ LAST: _____

NPI: _____ SPECIALTY: _____ DATE: _____

ADDRESS: _____

PHYSICIAN FAX: # (FOR FAXED NOTIFICATION): _____ CONTACT: _____

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