



PHARMACY PRIOR AUTHORIZATION AND NON-FORMULARY REQUEST

Date: _____

Type of Request: Standard
 Expedited

Medical Information

Requested Medication: _____

Dosing Regimen: _____

Quantity: _____

Duration of Therapy: _____

Diagnosis Pertaining to Requested Medication: _____

Reason for Exception Request: _____

Alternative Medications Tried and Reason(s) for Failure: _____

Member Information

Insurance Plan: Healthcare Group
 University Family Care
 Maricopa Health Plan
 University Physicians Care Advantage
 Maricopa Care Advantage

Member Name: _____

Insurance ID#: _____

Date of Birth: _____

Phone #: _____

Provider Information

Provider/Attending Name: _____

Phone #: _____

Fax #: _____

University Physicians Health Plans Office Use Only

Please fax this completed form to 866-349-0338