

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

Fax to (701) 234-4568

PO Box 91110  
Sioux Falls, SD 57109-1110  
Toll-Free: (855) 305-5062  
TTY/TDD: (877) 652-1844  
Fax: (701) 234-4568



**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. Fax completed form to the number above, or submit online through your provider portal at [sanfordhealthplan.com/providerlogin](http://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):	<input type="checkbox"/> MD <input type="checkbox"/> NP <input type="checkbox"/> DO <input type="checkbox"/> APRN <input type="checkbox"/> PA <input type="checkbox"/> _____
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: <input type="checkbox"/> New <input type="checkbox"/> Continuation of therapy ** If continuation, provide start date: _____	Expected length of therapy:	<input type="checkbox"/> 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:

Questions? Contact Pharmacy Management Department at (855) 305-5062 | TTY/TDD (877) 652-1844  
For free translation service, call (800) 892-0675

### 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)

- All fields must be completed and legible for review.
- **The Plan's decision will be based on individual plan policy and clinical documentation submitted.**
- Fax completed form to (701) 234-4568 or submit the request online in the Provider Portal at [sanfordhealthplan.com/providerlogin](http://sanfordhealthplan.com/providerlogin).
- **Prior authorizations cannot be completed over the phone.**

### Signature

Requesting Person/Authorized Representative Signature:

Printed Name: \_\_\_\_\_ Date Submitted: \_\_\_\_\_

Questions? Contact the Pharmacy Management Department at (855) 305-5062 | TTY/TDD (877) 652-1844  
For free translation service, call (800) 892-0675