Prescription Drug Prior Authorization Request and Formulary Exception

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Sioux Falls, SD 57109
(855) 305-5062
Fax: (701) 234-4568
sanfordhealthplan.com

Fax completed form and all supporting clinical information to Pharmacy Management Team at (701) 234-4568 or submit online at sanfordhealthplan.org/providerlogin.

This form is for: ☐ Formulary Exception ☐ Prior Authorization Request

Patient Information	Prescriber Information		
Patient Name:	Prescriber Name:		
Patient ID #:	Prescriber Specialty:		
DOB:	Address:		
Allergies:	City:	State:	Zip:

Diagnosis	
Diagnosis:	ICD-10 :

Phone:	Fax:
Contact Person at Prescriber's Office:	

Medication Information

Medication Being Requested:	Strength:	Directions:	Quantity	Days' Supply

Expected Length of Therapy:

Requested therapy medication is: ☐ new ☐ continuation of therapy
If continuation of therapy, provide start date:

Medical Rationale for Use:

Clinical Information

Please list all current and past medications and therapies the patient has tried specific to the diagnosis:

Medications/Therapies (if drug therapy, specify drug name and dose)	Dates of Therapy/ Treatment Duration	Outcome of Therapy (allergy, adverse event – specify and include severity, treatment failure, inadequate response)

Please list any medications specific to the diagnosis that are contraindicated or medically necessary to avoid (include rationale):

Other medical conditions to consider:

If request is for a formulary exception, explain why the preferred medication(s) would not meet your patient's needs.

Prescriber signature (same as prescriber listed above): Date of submission:

Attach additional sheets, lab results and other supporting documentation as necessary.
Questions? Contact the Pharmacy Management Department at (855) 305-5062 |TTY/TDD (877) 652-1844
For free translation assistance, call (800) 892-0675.

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