

Expedited Formulary Exception Request Form

Member Information

Patient Name _____
 Cardholder ID _____
 Date of Birth _____
 Address _____
 City, State Zip _____
 Phone Number _____

Provider Information

Provider Name _____
 DEA Number _____
 Address _____
 City, State and Zip _____
 Phone Number _____
 FAX Number _____

Pharmacy Information

Pharmacy Name _____ Address _____ Phone _____

Criteria for Approval:

1. Name of the drug for the expedited request: _____
2. What is the diagnosis of the patient? _____
3. Will applying the standard timeframe of 72 hours seriously jeopardize the life or health of the member or the member's ability to regain maximum function? Yes No
4. If answered **Yes** to question 3, please describe how the life or health of the member or the member's ability to regain maximum function may be jeopardized.

(May send any additional documentation to support this request.)

Provider Signature _____ Date _____

Fax completed forms to (866) 284-4509.

For Office Use Only

Date/Time Received _____
 Reference Number _____
 Approved / Denied (Circle One) by _____ Date _____
 Date/Time Returned to Provider _____

If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284-4492 or FAX Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
 3375-I Capital Circle NE
 Tallahassee, FL 32308

IMPORTANT NOTICE: This facsimile is intended to be delivered to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure and applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by other than the named addressee, except by express authority of the sender to the named addressee.

