



**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*