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EXPRESS SCRIPTS®
Charting the Future of Pharmacy

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PH # 1-800-417-8164

Prior Authorization & Not Covered Medication Request—FAX: 800-357-9577

Note: If the Following Information is NOT filled in completely, correctly, or legibly the authorization process **will be delayed**.

Health Insurance Company _____

Patients Prescription ID# _____

Patient Full Name _____

Patient Date of Birth _____

Medication Requested _____

Quantity Requested _____ **for** _____ **days supply**

Physician Name (please print clearly) _____

Physician Address _____

Physician Phone _____

Physician Fax _____

Diagnosis-Indication-Medical History (reason for use of this medication)

Other Medications/Therapies Tried and Reason(s) for Failure _____

Physician Signature _____ **Date** _____

Office Contact Person _____

Any further information pertaining to this drug request should be included and attached to this form.