

Ticket #: _____ Request Date: _____ Request Time: _____

PHYSICIAN CERTIFICATION COST EXCEEDS MAXIMUM REQUEST FORM

Please fill out the following information and return to us as indicated below.

A. Member Information			
Patient Name:		Plan Name/Plan ID:	
Patient ID:		Patient Date of Birth:	Patient Contact Phone #:
B. Physician Information			
Physician Name:		Physician Address:	
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG): ----- SEE BELOW -----	QTY and Days Supply: ----- SEE BELOW -----	NDC #:
C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:
D. Clinical Information (Please fill out the following clinical information.)			
Diagnosis/Indication:		ICD-9 Code: (if available)	
<p>1. Medical justification for <u>High Dollar Override</u>:</p> <p><input type="checkbox"/> The medication is medically necessary for this patient</p> <p><input type="checkbox"/> Formulary options would be hazardous to use</p> <p><input type="checkbox"/> Formulary options have been tried and have caused undesirable side effects or have been insufficiently effective</p> <p><input type="checkbox"/> Other:</p> <p>_____</p> <p>_____</p> <p>2. Dosing instructions per 30-day supply: _____</p> <p>3. Length of treatment requested at this dose: _____</p> <p>4. Is this patient receiving care in a long-term care facility? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>			
Authorized Medical Signature:			
Telephone:		Date:	

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736