FORMULARY EXCEPTION
PRIOR AUTHORIZATION
Physician Fax Form
(effective 1/1/2006)

ONLY the prescriber may complete this form.

The following documentation is REQUIRED for prior authorization. Incomplete forms will be returned for additional information. For formulary information, please visit the PrimeWest Health System web site at www.primewest.org.

Today's Date: ______________________

PATIENT INFORMATION

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):

INSURANCE INFORMATION

Member's Insurance ID Number:	Member's Insurance Group Number:

PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician UPIN#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:		Phone #:	Secure Fax #:

PRIOR AUTHORIZATION INFORMATION

Patient's Diagnosis:

Medication Requested:

1. Please list all previous medications and outcomes (if possible, please specify if brand name or generic products have been tried) ______________________________

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2. Please list all reasons for selecting the requested product over alternatives (e.g., contraindications, allergies or history of adverse drug reactions) ______________________________

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Please fax or mail this form to:
PrimeWest Health System
Clinical Review Department
1020 Discovery Road, No. 100
Eagan, Minnesota 55121

TOLL FREE	LOCAL
Fax: 866.469.5662	**Fax:** 651.286.4493
Phone: 800.711.9866	**Phone:** 651.286.4075

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