Formulary Exclusion Authorization Form

Allied Benefit Systems
P.O. Box 211651
Eagan, MN 55121

P Please refer to the phone number listed on the back of the member's ID card.
F 312-281-1636
E SpecialtyRx@alliedbenefit.com

All relevant information must be completed. This form is for **Formulary Specialty Exclusions only.** Allied's receipt of this completed form does not constitute a guarantee of benefits.

SECTION A - PATIENT INFORMATION

Patient's First Name		**Patient's Last Name**	
Employee's First Name		**Employee's Last Name**	
Employee's SS#		**Employee's ID#**	
Address		**City**	**State** / **Zip**
Home Phone	**Work Phone**	**Cell Phone**	
DOB			

SECTION B - PHYSICIAN INFORMATION

First Name			**Last Name**		
Address			**City**	**State**	**Zip**
Phone	**Fax**	**NPI #**		**DEA #**	
Office Contact Name			**Phone**		

SECTION C - CURRENT MEDICAL INFORMATION ONLY

Primary Diagnosis			**ICD-10 Code**		
Requested Medication Name	**Dose/Strength**	**Frequency**	**Directions**	**Quantity**	**# of Refills**
Tried and Failed Medications pertaining to request above.	**Dose/Strength**	**Frequency**	**Directions**	**Quantity**	**# of Refills**

Prescriber's Signature (required by law) _____ Date _____

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact Allied Customer Service at 1-800-288-2078. Customer Service hours are Monday – Thursday 7:30am-7:00pm central time, Friday 8:00am-5:00pm central time, and Saturday 9:00am-12:00pm central time.

Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.