



# 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](mailto: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.

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