



# Formulary Exclusion Authorization Form

Allied Benefit Systems  
PO Box 909786-60690  
Chicago, IL 60690-9786

P 800.288.2078  
F 312-281-1636

All relevant information must be completed below. Allied's receipt of this completed form does no constitute a guarantee of benefits.

SECTION A - PATIENT INFORMATION			
Patient First Name		Patient Last Name	
Subscriber First Name		Subscriber Last Name	
Address	City	State	Zip
Patient UID	Phone Number	DOB	

SECTION B - PRESCRIBER INFORMATION			
First Name		Last Name	
Address	City	State	Zip
Phone	Fax	NPI #	DEA #
Office Contact Name		Phone	

SECTION C - CURRENT MEDICAL INFORMATION				
Primary Diagnosis		ICD-10 Code		
Requested Medication	Strength	Directions	Quantity	# of Refills
Other Medications / Therapies tried and reason(s) for failure and/or any other information to review:				

Prescribers 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.

The document(s) accompanying this transmission may contain confidential health information. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you received this information in error, please notify the sender immediately and arrange for the return or destruction of the documents.