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.