



PHARMACY DEPARTMENT NON-FORMULARY / PRIOR AUTHORIZATION REQUEST

FAX COMPLETED FORM TO THE PHARMACY DEPARTMENT AT 954-858-3386. All sections and items on this form must be completed in order to receive a response. Allow results of requests to be faxed back to you within 2 business day. **Do Not Refax Request.** For Prior Authorization or Formulary questions please call 1-866-VISTARX.

Date	Plan <input type="checkbox"/> VISTA <input type="checkbox"/> Vista South Florida	
PATIENT INFORMATION		
Name		Member ID #
Daytime Phone	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB
PHYSICIAN INFORMATION		
Name		Specialty
Phone	Fax	
Physician Signature		Contact
MEDICATION INFORMATION		
Name of Medication		Strength
Directions	Quantity	# Of Refills
<input type="checkbox"/> NEW RX <input type="checkbox"/> REFILL If refill, how long has patient been on medication? _____		
MEDICAL RATIONALE FOR REQUEST		
Diagnosis		
Failure on Formulary Alternatives (<i>List failed Formulary medications and provide chart documentation.</i>)		
Medical Justification (<i>i.e. diagnostic references, lab, consultant reports, risk factors, chart documentation</i>)		
Healthplan Reviewer		
<input type="checkbox"/> Approved as requested Quantity _____		Valid through:
<input type="checkbox"/> Approved with changes Suggested Alternative(s):		
<input type="checkbox"/> Not Approved – Reason:		