☐ **Prior Authorization**
☐ **Formulary Exception**
☐ **Appeal**

Cleveland Clinic

Employee Health Plan Pharmacy Management

EHP
EHP Plus
Residents and Fellows
Retirees

Questions? Call: 216.986.1050, option 4; Email: EHPRxMgmt@ccf.org

Please complete this form and return via fax: 216.442.5790

Name of Member for whom medication is being ordered: _____

Member EHP Insurance ID Number: _____ **Member DOB:** _____

Requesting Physician's Name: _____

Office Phone Number: _____ **Office Fax Number:** _____

Requesting Physician's Signature: _____ **Date:** _____

Requesting Medication: _____

Strength: _____ **Quantity:** _____ **Dosage Regimen:** _____

Diagnosis: _____

Medical Rationale for Requested Medication: _____

_____

Formulary Agents Tried by the Member:

Drug & Strength	Dosing Regimen	Date Used (approximate)	Documentation of Treatment Failure

PLEASE NOTE: Please include any and all documentation pertaining to the request. Completion of this form does not guarantee approval. Requests are reviewed based on provided information. Decisions letters will be sent via fax to the requesting provider and to the member via US mail.