


- Prior Authorization**
- Formulary Exception**
- Appeal**



Cleveland Clinic

Employee Health Plan Pharmacy Management

Cleveland Clinic / Akron General
 Akron General ONA / Akron General USW
 Cleveland Clinic Weston
 Cleveland Clinic Martin Health
 Cleveland Clinic Indian River Hospital
 Cleveland Clinic Indian River Hospital Union
 Cleveland Clinic Out of Area
 Cleveland Clinic Retiree / Cleveland Clinic Florida Retiree

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 are generally made within two business days, but may take longer pending clinical review. Decisions letters will be sent via fax to the requesting provider and to the member via US mail.