✓ *Appropriate Box*

❑ **Prior Authorization**
❑ **Formulary Exception**
❑ **Appeal**

Cleveland Clinic Akron General
EHP Pharmacy Management

Questions? Call 216.986.1050, option 4 or 888.246.6648, option 4.

Please complete this form and return via fax: 216.442.5790.

Patient Name: ______________________________

Patient EHP Insurance ID Number: ______________ Patient 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: ______________________________

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Formulary Agents Tried and Failed by the Patient:

Drug & Strength	Dosing Regimen	Dates Used *(Approximate)*	Documentation of Treatment Failure

Note: Please include any and all documentation pertaining to the request. Completion of this form does not guarantee approval. Requests are reviewed on all available information. Decisions are generally made within two business days, but may take longer pending clinical review. Decision letters will be sent via fax to the requesting provider and to the patient via U.S. mail.

Internal Use Only: DO NOT WRITE BELOW

Medical	Pharmacy		MDR Outcome
Approved Tier 1	Initial Determination	Provider 1st Level	Approved
Approved Tier 2	Member 1st Level	Provider 2nd Level	Denied
Denied	Member 2nd Level	External Review	Peer-to-Peer

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