



**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.

✓ *Appropriate Box*

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

Member Name: _____

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 and Failed by the Member:

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 member 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