



**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

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

***Please complete this form and return via fax: 216.442.5790***

**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 by the Member:**

<b>Drug &amp; Strength</b>	<b>Dosing Regimen</b>	<b>Date Used (approximate)</b>	<b>Documentation of Treatment Failure</b>

**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.