AdvantraRx
Medicare Prescription Drug Plans Made Easy

First Health Premier
Medicare Prescription Drug Coverage

FORMULARY EXCEPTION/PRIOR AUTHORIZATION FORM

PLEASE FAX COMPLETED FORM TO: (800) 639-9158

Patient Name:	**Member ID #**
Date of Request:	**DOB:**
Requesting Physician:	**Office Phone #** **Office Fax #**

MEDICATION INFORMATION

1. Drug Requested:
(Please include: dose/frequency/length of therapy.)

2. Diagnosis:
(Please include all office notes supporting diagnosis.)

3. Previous agents tried:
(Include all office notes and supporting documentation.)

Drug:	Date(s) used:	Outcome:
Drug:	Date(s) used:	Outcome:
Drug:	Date(s) used:	Outcome:
Drug:	Date(s) used:	Outcome:

4. Other Supporting information:

Physician's Signature:

CHCH 2007-2(11/05)

For Urgent Requests please call (800) 551-2694
Visit our Websites at www.advantrarx.com and www.firsthealthpremier.com

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