



Express Scripts, Inc. (DIV – MNU)
 Prior Authorization Dept. BL 0345
 6625 West 78th Street
 Bloomington, MN 55439
 Phone: (877) 558-7521 Fax: (800) 357-9577

Medicare Part D Request Form

Type of Request Prior Authorization Formulary Exception Tier Exception Quantity Override

<input type="checkbox"/> STANDARD REVIEW (72 HOURS)		<input type="checkbox"/> EXPEDITED REVIEW (24 HOURS)	
By selecting the expedited review and signing this form below, I certify that applying the 72-hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.			
PATIENT INFORMATION		PRESCRIBER INFORMATION	
Patient Name:		Prescriber Name and Specialty:	
Member ID#:		DEA #:	
Sex (circle): Male Female		Office Phone:	
Date of Birth:		Office Fax:	
Patient Phone:		Contact Person:	
PHARMACY INFORMATION			
Pharmacy Name:	NABP#:	PHARMACY PHONE NO:	PHARMACY FAX NO:
DIAGNOSIS AND MEDICAL INFORMATION			
Medication:	Strength and Route of Administration:	Frequency:	
<input type="checkbox"/> New Prescription – OR – Date Therapy Initiated: / /	Expected Length of Therapy:	Quantity:	
Height & Weight:	Drug Allergies:	Diagnosis Related to Medication Requested:	
Rationale for Request			
List alternate drug(s) contraindicated or previously tried, but with adverse outcome(s) (e.g., toxicity, allergy or therapeutic failure): (1) Drug(s) tried; (2) adverse outcome for each; (3) dose and duration of therapy for each drug.			
(1) _____		(2) _____	
(1) _____		(2) _____	
(1) _____		(2) _____	
Additional Medical Justification			
Telephonic requests are preferred as they allow for a more efficient determination by ensuring that all of the necessary information is obtained during the initial contact. If you choose to fax this form please provide any additional information that may be needed to approve this request.			
Prescriber's Signature:		Date:	