Value Formulary Exception Prior Authorization Request Form (Page 1 of 2)

Insurance ID#: NPI#: Specialty: Date of Birth: Office Phone: Street Address: Office Fax: City: State: Zip: Office Street Address: Phone: City: State: Zip: Zip: Zip: Medication Information (required)		DO NOT COPY	FOR FUTURE USE. FO	RMS ARE UPDATED FREG	UENTLY AND MAY B	E BARCODED	
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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

This request may be denied unless all required information is received. Please note:

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