

Providers, please have the information below ready when calling in the authorization.

Last Name:	First Name:
SCAN ID number:	Date of Birth:
Physician Name:	Specialty:
Telephone:	Fax:

Name of the non-formulary prescription that the member or MD is requesting, dose/directions, date the member began taking the medication and anticipated duration of therapy.	
Medication:	Dose/Directions:
Date:	Anticipated duration of therapy:
Please provide the following information.	
What is the member's diagnosis or the specific disease state being treated?	
Has the member tried and failed formulary drug(s) for the diagnosis provided? (Please indicate current and previous medication therapies)	
<u>Drug</u>	<u>Dose</u> <u>Date/Duration of Therapy and Outcome</u>

Has the member experienced an allergic reaction to the formulary drug(s)? If yes, please provide the name of the drug(s) and allergic reaction: _____	
Has the member experienced an adverse drug reaction to the formulary drug(s)? If yes, please provide the name of the drug(s) and adverse drug reaction: _____	
Does the member have contraindications to the formulary drug(s)? If yes, please provide any known contraindications for use: _____	
Is the medication being requested for a FDA-approved indication?	
Are there any other comments, diagnoses, symptoms, and/or any other information is important to this review?	

Notice: Failure to provide all information requested on this form may result in delayed processing or an adverse determination for insufficient information. Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.