

## Member Pays the Difference (MPD) Exceptions Prior Authorization Request Form

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Member Information (required)			Provider Information (required)			
Member Name:			Provider Name:			
Insurance ID#:			NPI#:	Specialty:		
Date of Birth:			Office Phone:			
Street Address:			Office Fax:			
City:	State:	Zip:	Office Street Address:			
Phone:			City:	State:		Zip:
		Medication In	formation (	required)		
Medication Name:			Strength:	Strength: Dosage Form:		orm:
Check if requesting brand			Directions for Use:			
Check if request is	for <b>continuation o</b> f	f therapy				
		Clinical Info	ormation (req	uired)		
<b>Diagnosis:</b> What is the patien ICD-10 Code(s):	-	the medication being	requested?			
Answer the follow	wing:					
Has the patient tri	ed and failed the	e generic? 🛛 Yes 🔾	No			
Does the patient h	ave a documen	ited allergy to the gene	eric? 🛛 Yes 🗆	No		
Does the patient h brand?		al reasons (e.g., drug	interactions, sa	ifety concerns) r	equiring th	ne

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received. For urgent or expedited requests please call 1-800-711-4555. This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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