Formulary Exclusion Authorization Form

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All relevant information must be completed below. Centrix's receipt of this completed form does not constitute a guarantee of benefits.

SECTION A - PATIENT INFORMATION

Patient First Name	Patient Last Name		
Subscriber First Name	**Subscriber Last Name**		
Address	**City**	**State**	**Zip**
Patient ID	**Phone Number**	**DOB**	

SECTION B - PRESCRIBER INFORMATION

First Name	Last Name		
Address	**City**	**State**	**Zip**
Phone	**Fax**	**NPI #**	**DEA #**
Office Contact Name	**Phone**		

SECTION C - CURRENT MEDICAL INFORMATION

Primary Diagnosis	ICD-10 Code

Requested Medication	Strength	Directions	Quantity	# of Refills

Other Medications / Therapies tried and reason(s) for failure and/or any other information to review:

Prescribers Signature (required by law)

Date

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact Centrix Customer Service at 1-800-585-5965. Customer Service hours are Monday – Thursday 8:00am - 5:00pm Pacific Standard time (PST), Friday 8:00am-3:00pm PST.

Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.