THE PBAS GROUP

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Application for Prior Authorization or Drug Exception

Exceptions to the Drug Plan will only be granted if there is a documented medical need for a medication that is not included on the Drug Formulary used by this Plan. The exception will only be made for drugs which legally require a prescription and at least one alternative drug, eligible under the Formulary, has been tried but was unsuccessful in treating your condition. Applications for drugs specifically excluded under the plan will not be considered.

SECTION 1: PLAN MEMBER INFORMATION to be completed by Plan Member/Patient		
Plan Member's Full Name (first, middle, last)		Plan Member's Certificate Number
Patient's Full Name, if different than Plan Member (first, middle, last)		Patient's Date of Birth (mm/dd/yyyy)
Patient's relationship to member __ Self __ Spouse __ Dependant	Phone Number	Email
Address		
I hearby authorize PBAS and/or it's affiliates, to use the information provided herein and/or to consult with the physician named below to determine eligibility for special authorization of drug benefits. **Signature of Patient/Legal Guardian** **Date**		

SECTION 2: PHYSICIAN'S STATEMENT to be completed by your Physician		
NOTE: Any expense for medical evidence to support your claim is the responsibility of the plan member.		
Drug Name	Dose	Drug Identification Number (DIN)
Reason for Prior Authorization Request/Exception (Diagnosis)		
Has an alternative eligible drug been tried, and was unsuccessful in treating this condition? __ **Yes** __ **No** __ **N/A** **If Yes:** Drug Name: Dose/DIN: Date tried: **If No,** Please attach a physician's note citing the medical reason why no alternative has been tried (allergies, comordibities, etc).		
Attending Physician's full name (please print)		Area of Specialization
License Number	Email	Phone
Address		
Physician Signature Electronic signatures are only accepted with proof of authenticity.		Date