FREEDOM HEALTH PLAN
MEDICATION THERAPY REVIEW

INSTRUCTIONS:

- **PLEASE FAX THE COMPLETED PRIOR AUTHORIZATION/STEP THERAPY REQUEST TO THE PHARMACY DEPARTMENT VIA FAX number: (1-844-430-1704)**
- **NOTE: ANY MEMBER OF THE PHYSICIAN'S STAFF MAY COMMUNICATE THIS INFORMATION TO FREEDOM HEALTH PLAN. FOR AN EXPEDITED REQUEST CALL BY PHONE: (1-833-272-9772)**

PATIENT INFORMATION

LAST NAME: **FIRST NAME:** **MI:**

PATIENT ID NUMBER:

DATE OF BIRTH:

PHARMACY: **PHARMACY PHONE:**

DRUG REQUESTED

NAME: **STRENGTH:** **QUANTITY:** **DURATION OF THERAPY:**

1. HAS THIS PATIENT PREVIOUSLY RECEIVED THIS DRUG? ☐ **YES** ☐ **NO IF YES, HOW LONG?** _____

START DATE: _____

2. HAS PATIENT HAD A DOCUMENTED ALLERGY/INTOLERANCE TO SIMILAR FORMULARY MEDICATIONS?

☐ **YES** ☐ **NO** ☐ **N/A**

3. LIST THERAPY FAILURE ON ONE OR MORE FORMULARY DRUGS WITHIN THE SAME THERAPEUTIC CLASS:

4. PATIENT DIAGNOSIS:

Please include all relevant documentation, including the most recent tests, procedures, prior therapies tried and failed, etc., to support your request for this drug.

It is important that the following information is filled in completely in order to successfully process your request.

PHYSICIAN NAME: **PHYSICIAN PHONE #**

FIRST: **LAST:**

NPI: **SPECIALTY:** **DATE:**

ADDRESS:

PHYSICIAN FAX: # (FOR FAXED NOTIFICATION): **CONTACT:**