DRUG COVERAGE REQUEST FORM

Prescribing Provider: Complete & fax to 1-866-618-6569

To review formulary alternatives that may be appropriate for your patient, please refer to the Kaiser Permanente drug formulary at www.kp.org/formulary or consult with a pharmacist at 503-261-2075 or toll-free 1-888-572-7231, Monday-Friday, 8 a.m. to 6 p.m.

1. Patient name: _____HRN:_____DOB:_____

2. Medication (name & strength):_____

3. Indication for use: _____

4. Is this a new medication for the patient? ❑ YES ❑ NO

5. Medications previously tried by patient:

Drug and Strength	Dates Used (approx)	Reason for Discontinuation

6. Rationale for prescribing this medication: _____
_____
_____
_____
_____

7. Do you believe that the alternative medication(s) on the formulary are not as effective in treating the member's condition and/or would cause the member to have adverse medical effects?

❑ YES ❑ NO

8. *I acknowledge that the information I have provided is true and accurate.*

Prescriber Name (print): _____

Clinic Name:_____Address: _____City: _____

Phone: _____FAX: _____

Provider Signature:_____ Date: _____