

NON-PREFERRED DRUG AUTHORIZATION REQUEST

Submit form to: Kenai Peninsula Borough School District

ATTN: Stacey Gorder, Employee Benefits Manager

148 N. Binkley St. Soldotna, AK 99669 *OR* Fax to: (907) 262-9645

Patient Name (last,first,MI):	Patient ID Number:
Sex: DOB:	Phone Number:
Insured's Name:	
Name of Member's Health Plan: Rehn & Associates	
Date of Request:	Physician's Name:
MD office Contact Person:	Physician's Phone Number:
Physician's Fax Number:	Physician's Specialty:
Pharmacy Name:	Pharmacy Fax Number:
Pharmacy Contact:	Pharmacy Phone Number:
MEDICATION REQUEST *Physician's Signature:	
Medication request information is to be completed by a physician.	
DIAGNOSIS (list relevant):	
CURRENT MEDICATION(S):	
FORMULARY & GENERIC DRUGS TRIED & MEDICAL JUSTIFICATION:	
DRUG & STRENGTH:	NDC:
DIRECTIONS:	MONTHLY QTY: #REFILLS:
DIRECTIONS.	WOMILI QII. #REFILLS.
FOR INTERNAL USE ONLY	
Approved Denied Deferred for Additional Information	<u> </u>
COMMENTS:	
Authorizing Signature	Date

Instructions for the KPBSD Non-Preferred Drug Authorization Request form

The purpose of this form is to allow a non-formulary drug at the formulary price if due to side-effects, complications, or intolerance, the member cannot use a preferred or generic substitute; or the clinical efficacy of the non-preferred drug has been shown to exceed the effectiveness of the referred or generic alternative.

The employee or eligible dependent may fill out the top section which includes their Name, ID number, Sex, DOB, Phone number, Physician's office information and Pharmacy information.

The physician MUST sign the form and completely fill out the section titled "Medication Request". Before submitting the form, please verify that the information provided is legible.

Once the form has been completed it may be submitted via fax or mail.

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