



# PreferredOne

## PA / Drug Evaluation Review Form

**FAX completed form to: PreferredOne Pharmacy  
Toll Free Fax 1-866-388-1517**

Instructions: This form is used by participating physicians and providers to obtain coverage for a drug for which there is medical criteria protocol established by the Pharmacy & Therapeutic Committee at PreferredOne Health Plan.

The Following Review Criteria Are Used In Reviewing Drug Evaluations And Overrides:

- Other therapeutically equivalent medications are contraindicated in the patient.
- Patient has failed an appropriate trial of suggested related agents.
- Choices available are not suited for the present patient care and the drug selected is required for patient safety.
- An alternative choice may provoke an underlying medical condition, which would be detrimental to patient care.

### Complete Each Section Legibly

Member Name		Date of Request
Health Plan ID#		Health Plan PreferredOne
DOB		Physician Name
Diagnosis		Specialty
Drug Name		Sent By
Dose		Physician's Phone
Dosage Form		Physician's Fax
Strength	Qty	Pharmacy Phone
Length of Treatment		
Clinical Reason for Override (include medical documentation, if necessary)		Previous medications that failed (include drug, dose, strength)
History		

**For Internal Use Only**

