REQUEST FOR DRUG EVALUATION

(To be used for Quantity Limits, Coverage Determinations, General Exceptions or drugs without a unique P.A. form)

TO CALL THIS INFORMATION INTO THE FLRx PHARMACY HELP DESK DIRECTLY;

PHONE #: 1(800) 499-1275

FAX#: 1(800) 956-2397

Please complete all of the following information:

Patient Name: (Please Print)	
FLRx Patient ID number:	**Patient Birthdate:**
MD Name:	**MD Specialty:**
MD Phone #: ( )	**MD FAX #: ( )**
MD DEA #:	**MD NPI #:**

1. Requested drug information:

Drug Name	Strength	Quantity	Directions for use

☐ New Start ☐ Continued Therapy Start Date: ______________

2. Primary diagnosis: ____

Is the patient's diagnosis related to Workers Compensation or Motor Vehicle Accident?

☐ YES ☐ NO If yes, please submit to appropriate carrier

3. Previous therapies attempted:

☐ **NONE**

Drug:______________ Dosage & Freq:___________ Period of Use:_____to _______
☐ Drug was not effective ☐ Effectiveness diminished ☐ Adverse reaction
Please provide details: ____

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☐ Drug was not effective ☐ Effectiveness diminished ☐ Adverse reaction
Please provide details: ____

4. Explanation of medical necessity: ____

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I certify that the above information is true and accurate to the best of my knowledge.

Please add your electronic signature below or print this document and provide your handwritten signature to avoid delays.

Provider Signature:_______________________________________ **Date**________________

If preferred, a letter of medical necessity may be attached to this form and submitted with the appropriate patient information.