univera HEALTHCARE

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: _____

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

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

4. Explanation of medical necessity: _____

_____

_____

5. 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.