KAISER PERMANENTE®
GEORGIA

# Non-Formulary or Step Therapy Prescription Drug Form

**Fax to 404-467-2731**

**Member Name (print):** _____

**Kaiser Permanente Health Record Number:** _____ **DOB:**_____

**Print or Stamp below:**
**Prescriber Name:**

**Prescriber Phone number:**

**Prescriber Fax number:**

**Office Address:**

**Please note for criteria restricted medications (Prior Authorization) on the Targeted Review List, the provider should call Quality Resource Management at 404-364-7320 (Option 3) or fax 866-452-4585.**

The Kaiser Permanente Georgia Formulary is developed by doctors and pharmacists who meet regularly to review and revise the formulary, considering new medicines as they become available. The prescription drug benefit does not routinely cover medications *not* listed on our Drug Formulary. If a medication on our Drug Formulary cannot be prescribed *for medical reasons*, the prescription drug plan may cover a Non-formulary or step therapy medication. Prescribers must determine if a Formulary medication cannot be prescribed and provide all requested documentation below.

Diagnosis / Indication for Non-formulary or step therapy drug:

☐ Privileged Diagnosis

☐ Check here if member will pay full retail price for this Non-formulary or step therapy prescription (non-covered) & skip to prescription section below. (*If not checked, complete all sections below*)

| **Health Record documentation for the following exists for this pt (check all that apply):** | YES | NO |
|---|---|---|
| Lack of efficacy with Formulary medications (*if yes, complete section below*) | | |
| Intolerable side effects with Formulary medications (*if yes, complete section below*) | | |
| Formulary medications contraindicated (*if yes, complete section below*) | | |

Formulary drugs *used or considered* for this diagnosis:

| Formulary Drug Name / Dose | Describe response to treatment, or<br>Specify type of intolerance or allergy, or<br>List contraindication to formulary drug |
|---|---|
| | |
| | |
| | |
| | |

Write Non-Formulary or Step Therapy Prescription Below
(***one prescription per form***, up to 30 day supply recommended for initial therapy)

Rx

DEA# _____

Prescriber Signature _____ Date _____

THIS FORM IS FOR KAISER PERMANENTE GEORGIA ONLY