

# FAX

**Date & Time:**

**Deliver To:**

**Fax Number:**

**From:**

**Phone Number:**

**Subject:**

**INFORMATION REQUESTED**  
for Prescription Substitution Request

**CONFIDENTIALITY NOTICE:** This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution, or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.

# ADDITIONAL INFORMATION REQUESTED REGARDING YOUR PHARMACY'S REQUEST TO SUBSTITUTE



**FOR OFFICE USE: PLEASE COMPLETE BEFORE SENDING TO THE PHARMACY**

Patient's Name: \_\_\_\_\_  
 Practice/Office Name: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 Office Fax Number: \_\_\_\_\_ Office Phone Number: \_\_\_\_\_

**OUR OFFICE WILL USE THE INFORMATION YOU ENTER BELOW TO FURTHER UNDERSTAND AND EVALUATE YOUR PHARMACY'S REQUEST TO SUBSTITUTE PRESCRIBED MEDICATION FOR THE PATIENT LISTED ABOVE.**

**FOR PHARMACY USE: PLEASE ANSWER THE FOLLOWING QUESTIONS:**

- 1 **Is the patient waiting at your pharmacy for the prescription to be filled?**  
 YES (please contact our office for immediate reconciliation)     NO (please continue to the next question)
- 2 **What is the patient's prescription plan information (so our office can verify cost, coverage, and other plan requirements)?**  
 Prescription Insurance Plan Name: \_\_\_\_\_ Plan Phone Number: \_\_\_\_\_  
 BIN: \_\_\_\_\_ PCN: \_\_\_\_\_ Rx Group: \_\_\_\_\_
- 3 **What type of medication substitution is being requested?**  
 Therapeutic Equivalent     Generic Substitution    Drug Name: \_\_\_\_\_
- 4 **Was "dispense as written/brand medically necessary/do not substitute" checked on the prescription?**     YES     NO
- 5 **Is this substitution request mandated by the patient's prescription insurance?**  
 YES:  
 75—Prior Authorization Required     608—Step Therapy     70—Product Not Covered  
 Other    Rejection Code: \_\_\_\_\_ Description: \_\_\_\_\_  
 NO (please provide reason):  
 There is a lower-cost alternative (alternate medication name): \_\_\_\_\_

**Please provide cost and duration after running the patient's prescription insurance:**

MEDICATION	COST	DURATION	DID YOU PROCESS THE XIIDRA SAVINGS CARD?
Prescribed Medication	\$ _____	Days _____	<input type="radio"/> YES (cost): \$ _____ <input type="radio"/> NO (explanation): _____
Alternate Medication	\$ _____	Days _____	

- Prescribed medication is out of stock  
 How long will it take to fill the prescription? \_\_\_\_\_ Is there a nearby pharmacy that could fill the prescription?     Yes     No
- Other (explanation): \_\_\_\_\_

**PLEASE FAX THIS COMPLETED FORM (ALONG WITH A HIPAA-COMPLIANT COVER SHEET)  
TO OUR OFFICE (SEE FAX NUMBER AT THE TOP OF THIS FORM).**

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