Non Formulary Change / PA Request
for Medication Already Sent to Facility

Facility/Wing:
Account:
RX#:

Resident:
Medication:
DOS:

The above medication is:

Not covered by the residents plan and/or

Requires prior authorization and/or

Plan limitation exceeded and/or

Other

CPS suggests the following preferred alternative:
Covermymeds Key:

If there is no therapeutic substitution available or the physician **DOES NOT** wish to change the medication, please call the resident's drug plan to receive authorization for the above DOS.

Phone: **Resident's ID#:**
Resident's DOB:

The above medication has already been sent out to the facility for the resident's use.

The facility can either: (Choose 1)

Pay the cost of the medication **UNTIL** an approval has been given for the DOS
QTY: Day Supply: Cost: $

Return the medication in the full quantity and wait on approval

Return portion of the medication and charge the facility only for the portion kept

Must be signed by DON or other authorized personnel. Facility must pick one option above.
*Please email approval to: hpoling@completepharmacysolutions.com

Signature: ________________________________ Print Name: _____________________________

Thank You!