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www.wellspanpophealth.org

WELLSPAN® HEALTH

Population Health Services

Pharmacy Review Form

Request will only be reviewed if clinical information is provided in addition to this form

Date: _____

Patient's ID#: _____

Name of Patient: _____ DOB of Patient: __/__/____

Ordering Physician's Name: _____

Ordering Physician's Phone Number: _____ Fax Number: _____

Medication: _____

Prescription Order: dosage: _____

Frequency: _____

Quantity: _____ Diagnosis code(s): _____

How long has the patient been using this drug or is it a new prescription? _____

Medication to be obtained from a Pharmacy? _____ **OR** Buy and Bill? _____

Name of person completing the form: _____

Name and Phone Number of the person to contact with the outcome of the review:

_____

FAX the form back along with the following information:

- **Clinical information from the last two office visits AND**
- **Any clinical information pertaining to the prescribed medication; if appropriate alternative drugs tried and failed with reasoning**
- **Include any correspondence received from OptumRX or the pharmacy filling the Rx (e.g. OptumRX denial, PA request received from pharmacy)**

**** FAX to 717-851-6798 **"Attention: Pharmacy Review"****