

The following documentation is **REQUIRED** for review. Incomplete forms will be returned for additional information.

**Patient Information**

Today's Date: \_\_\_\_\_

Patient Name (First):	Last:	MI:	DOB (mm/dd/yyyy):	Telephone Number:
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**Insurance Information**

ID Number:
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**Physician/Clinic Information**

Prescriber Name:	Physician UPIN#:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:			
City, State, Zip Code:		Phone Number:	Secure Fax Number:	

**Formulary Review Information**

Medication Requested: _____
Medication Dose Requested: _____
Diagnosis: _____
Height: _____ Weight: _____
1. Is the patient currently being treated with the requested medication: <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Please list all medications the patient has previously tried and failed for treatment of this diagnosis: _____ _____ _____
3. If any, please provide documentation that all formulary alternatives are contraindicated, likely to be less effective, will cause an adverse reaction or other harm that is not seen with the requested medication, or what risks are associated with changes in therapy: _____ _____ _____

**Please fax or mail this form to:**

 Detego Health, LLC  
 759 N 114th St #300  
 Omaha, NE 68154

**Toll Free Fax:** 855-613-4102

**Phone:** 866-815-6001

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