1. What is the diagnosis? _________________________________________________________

2. Has the member tried the generic equivalent product?
   □ Yes:
   a. When did the member try the generic (please provide date)? _________________
   b. Please provide clinical rationale as to why the generic was discontinued. If generic was discontinued due to side effects or allergic reaction, please specify/describe the side effects/allergic reactions the member experienced
       _________________________________________________________________________
       _________________________________________________________________________
   □ No:
   a. Please provide the clinical reason why the member has not tried the generic.
       _________________________________________________________________________
       _________________________________________________________________________
   b. Can the member be switched to the generic version of the medication?
      □ Yes: Please call the pharmacy and notify them of the change.
      □ No: Please provide clinical rationale as to why the member cannot try the generic.
       _________________________________________________________________________
       _________________________________________________________________________

3. Has the member tried other formulary medications?
   □ Yes: Please provide the names of other medications the member has tried and the specific reason why each was discontinued.
       _________________________________________________________________________
       _________________________________________________________________________
   □ No: Please provide the reason why the member has not tried other formulary medications.
       _________________________________________________________________________
       _________________________________________________________________________

*Form must be completed and signed by physician or licensed representative from the physician’s office