Therapeutic Interchange Request Form

Date request received: _____

Requesting Pharmacy Information

Date request submitted: M M / D D / Y Y Y Y	**Pharmacy contact person:**
Pharmacy Name:	**Pharmacy NPI:**
Phone: (XXX) XXX-XXXX	**Fax:** (XXX) XXX-XXXX

Prescriber Information

Prescriber Name:	**Prescriber NPI:**
Practice/Facility Name:	**Practice Address:**
Phone: (XXX) XXX-XXXX	**Fax:** (XXX) XXX-XXXX

Patient Information

Patient Name:	**Date of Birth:** M M / D D / Y Y Y Y
Member/Rx ID#:	**Patient Phone:** (XXX) XXX-XXXX
Insurance/Plan Name:	**BIN/PCN:**

Current Medication

Drug Name/Strength	NDC	Qty	Days Supply	Refills

Requested Therapeutic Alternative

Drug Name/Strength	NDC	Qty	Days Supply	Refills

Interchange Type (check one)

☐ Generic Substitution ☐ Therapeutic Alternative ☐ Formulary Preferred

Clinical Rationale for Therapeutic Interchange

Estimated Cost Information

Current Cost/Fill: $	**Alternative Cost/Fill: $**	**Est. Annual Savings: $**

Prescriber Response (check one)

☐ APPROVED - Please change prescription as requested above ☐ DENIED - Continue current medication

If denied, reason:

Prescriber Authorization

Prescriber Signature: _____ **Date:** M M / D D / Y Y Y Y

Response Instructions