



**Ventura County
Medical Center**

ACE PROGRAM MEDICATION OVER-RIDE JUSTIFICATION FORM

Requested by (Provider) _____ Date of request _____

Clinic _____

Phone number _____ FAX _____

Patient name _____ ACE Enrollment # _____

Patient DOB _____ **Diagnosis** _____

Medication(s)/Dose/Route/Frequency/Quantity for month:

Reason for non-formulary prescription/medication over-ride: _____

FOR ACE OFFICE USE ONLY:

(Tier 1) Approved indefinitely _____

(Tier 2) Approved for 2 mths. then PAP _____

(Tier 3) Approval with PAR _____

Provider notified of non-approval and reason _____ Date _____

E-Scripts notified: Date _____ Over-ride period _____

Comments _____

Signature _____ Date _____

ACE PROGRAM
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