Formulary Exception Form

Phone 855-323-4588 / Fax 855-323-4586

**** Only one medication request per form *** All fields must be complete and legible for review ****

Date of Request: _____

Patient Information	Prescriber Information
Patient Name:	Prescriber Name and Specialty:
Member ID#:	NPI#:
Sex (circle): Male Female	Office Phone: ( ) -
Date of Birth:	Office Fax: ( ) -
Patient Phone: ( ) -	Contact Person:

Diagnosis and Medical Information

Medication:	Strength and Dosage Form:	Frequency/Quantity:
□ New Prescription ~ or ~ Date Initiated: / /	Drug Allergies:	Expected Length of Therapy:
Height and Weight:	Diagnosis Related to Medication Request:	

Rationale for Exception Request

□ List all medications that were trialed and failed including dose, duration and outcome of each drug:

_____

_____

_____

In order to complete the review process, please include chart notes documenting trial and failure on the above medications

□ Complex patient with two or more chronic conditions is stable on current drug(s); high risk of significant adverse clinical outcome with medication change. Specify the anticipated significant adverse clinical outcome: Attach documentation

□ Clinical rationale for treatment: Attach documentation

□ Pertinent Laboratory Tests and Results: Attach copies of results

**** All Criteria on Checklist must be Met in Order for Exception to be Approved ****

□ Requested drug is FDA Approved.

□ There has been an adequate trial and failure of all formulary and State Carve Out medications. Attach documentation

□ Member has contraindications to, or an intolerance of, formulary medications. Attach documentation

□ The requested exception is considered the Standard of Care as evidenced by accepted Clinical Practice Guidelines developed by the appropriate medical specialty and supported by at least two (2) peer-reviewed journal articles that are: randomized, double-blinded, against placebo and/or alternative therapy. Attach documentation

Prescriber's Signature:	Date: