

**** 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:
<input type="checkbox"/> New Prescription ~ or ~ Date Initiated: / /	Drug Allergies:		Expected Length of Therapy:
Height and Weight:	Diagnosis Related to Medication Request:		
Rationale for Exception Request			
<input type="checkbox"/> 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			
<input type="checkbox"/> 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: <u>Attach documentation</u>			
<input type="checkbox"/> Clinical rationale for treatment: <u>Attach documentation</u>			
<input type="checkbox"/> Pertinent Laboratory Tests and Results: <u>Attach copies of results</u>			
** All Criteria on Checklist must be Met in Order for Exception to be Approved **			
<input type="checkbox"/> Requested drug is FDA Approved.			
<input type="checkbox"/> There has been an adequate trial and failure of all formulary and State Carve Out medications. <u>Attach documentation</u>			
<input type="checkbox"/> Member has contraindications to, or an intolerance of, formulary medications. <u>Attach documentation</u>			
<input type="checkbox"/> 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. <u>Attach documentation</u>			
Prescriber's Signature:			Date:

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (Via return FAX) immediately and arrange for the return or destruction of these documents.