



ILLINOIS Formulary Exception Form

Phone: 855-580-1688 / Fax: 855-580-1695



**** 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: Attach documentation			
<input type="checkbox"/> Clinical rationale for treatment: Attach documentation			
<input type="checkbox"/> Pertinent Laboratory Tests and Results: Attach copies of results			
<hr/>			
** 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. Attach documentation			
<input type="checkbox"/> Member has contraindications to, or an intolerance of, formulary medications. Attach documentation			
<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:	

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