Request for Prescription Drug Coverage Exception

Please use this form as guidance if you are submitting an initial determination or exception request.

Please note: If you are appealing a previous adverse decision, call the number on the back of your patient's ID card.

Member's Information (as it appears on the member's ID card)

[First Name]

[Last Name]

[Date of Birth] (Month Day Year)

[Phone Number]
[Address Line 1]
[Address Line 2]
[City]
[State]
[Zip Code]
[Member Number]
[Group ID Number]
[Requestor's Name] (if not the member)
[Requestor's Relationship to the member]
[Name of Prescription Drug you are Requesting] (if known, include strength and quantity requested)

[Name of condition]

[Patient Diagnosis] (related to this request)

[Prescribing Physician Information]

[First Name]

[Last Name]

[State]

[Address Line 1]
[Address Line 2]
[City]

[State]
[Zip Code]
[Medical Specialty]
[Office Contact Person]
[Work Phone]
[Fax]
[Type of Exception Request]

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

Please select the option below that best describes your request
[ ] I need a drug that is not on the plan's list of covered drugs (formulary exception)
[ ] Other

If you believe that waiting for a standard decision could seriously harm your patient’s life, health, or ability to regain maximum function, you can ask for and we will give you an expedited decision.
[ ] I need an expedited decision.