



Non-Formulary Exception Request

****ONLY COMPLETED REQUESTS WILL BE REVIEWED****

Date: _____

Drug requested: _____
(one drug per form only)

Quantity: _____
(quantity edit only)

Patient name: _____

Prescribing physician: _____

Patient ID #: _____

Provider NPI: _____

Patient DOB: _____

Office contact: _____

Office fax #: _____

Office phone #: _____

1. Provider specialty *(specify all)* _____

2. Diagnosis for drug requested *(specify all)* _____

3. Medication history *(Please list any previous or current therapy related to the diagnosis below using drug names and dates.)*

N/A *(If none or not applicable to diagnosis, check N/A.)*

Drug name	Date	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please add any other supporting medical information that may be useful in the decision-making process:

Please fax your completed form to 1-888-671-5285. Your office will receive a response via fax or mail.

For internal use only

Coverage effective date: ____ / ____ / ____

Document #: _____ Rx coverage: Y N

Approved

Processor initials: _____ Prior auth: Y N STANDARD – SELECT

Reviewer initials: _____

Date: _____ Sex: M F LOB: _____

Date approved: _____