



# Non-Covered Pharmaceutical Exception Request

**Please Type or Print**

Complete this form and fax to:  
Pharmacy Management Department: 1-888-343-4232

Date	Drug Requested <i>(one drug per request)</i>	Quantity Prescribed
_____	_____	_____

Member	Prescribing Practitioner
Name _____	Name _____
Member ID No.: _____	Office Fax No.: _____
DOB: _____	Office Phone No.: _____

Medical condition for drug requested: \_\_\_\_\_

Expected duration of drug treatment: \_\_\_\_\_

## Medication History

Please list any previous or current drugs related to the medical condition, including drug names and treatment dates. Current drugs are defined as drugs used by the member within the last 30 days. For previously prescribed drugs, include beginning and ending dates of treatment.

If none or not applicable to diagnosis, check "N/A"

N/A

Drug Name		Dates and Duration of Treatment
_____	<input type="checkbox"/> Current <input type="checkbox"/> Previous	_____
_____	<input type="checkbox"/> Current <input type="checkbox"/> Previous	_____
_____	<input type="checkbox"/> Current <input type="checkbox"/> Previous	_____
_____	<input type="checkbox"/> Current <input type="checkbox"/> Previous	_____

Please add any supporting medical information that may be useful in considering the request for a coverage exception. Additional documents of supporting medical information may be included with your exception request.

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