



Tiering Exception Request

Complete this form to request an exception for the patient to receive the non-formulary medication at the formulary brand copay.

Patient Information		
Patient Name:		
Date of Birth:		
Plan Member ID Number:		
Prescriber Information		
Prescriber Name:		
Prescriber Phone Number:		
Prescriber Fax Number:		
The following sections to be completed by the prescriber. (Incomplete or missing information may delay processing and result in the form being returned to the requester.)		
Non-Formulary Brand Drug Name:		
Strength:	Dosage Form:	Diagnosis:
1. Does the patient have a documented contraindication to, or a potential drug interaction with, the formulary alternatives?		
2. Is the patient intolerant to, or had a confirmed adverse event with, the formulary alternatives?		
3. Has the patient experienced an inadequate treatment response with TWO formulary alternatives?		
4. Has the prescriber determined that the formulary medication is not appropriate based on a specific clinical concern not listed above? If yes, please document.		
As the prescriber for the brand-name drug above, I certify that the information provided is accurate and complete.		
Prescriber Signature: _____ Date: _____		
Fax the completed form to the Exceptions Department at 1-888-487-9257.		