



### Tiering Exception Request

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

<b>Patient Information</b>		
Patient Name:		
Date of Birth:		
Plan Member ID Number:		
<b>Prescriber Information</b>		
Prescriber Name:		
Prescriber Phone Number:		
Prescriber Fax Number:		
<b>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.)</b>		
Non-Formulary Brand Drug Name:		
Strength:	Dosage Form:	Diagnosis:
<ol style="list-style-type: none"><li>1. Does the patient have a documented contraindication to, or a potential drug interaction with, the formulary alternatives?</li><li>2. Is the patient intolerant to, or had a confirmed adverse event with, the formulary alternatives?</li><li>3. Has the patient experienced an inadequate treatment response with <b>TWO</b> formulary alternatives?</li><li>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.</li></ol>		
As the prescriber for the brand-name drug above, I certify that the information provided is accurate and complete.		
Prescriber Signature: _____ Date: _____ <b>Fax the completed form to the Exceptions Department at 1-888-487-9257.</b>		