



## 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: \_\_\_\_\_