



Formulary Exception Form

FAX: (313) 664-5460

** Only ONE (1) Medication per request form **

Date of Request: _____

Patient Name:		Prescriber Name and Specialty:	
Member ID#:		NPI#:	
Sex (Circle):	Male	Female	Office Phone:
Date of Birth:		Office Fax:	
Patient Phone:		Contact Person:	
Medication:		Strength and Dosage Form:	Frequency and Quantity:
Date of Rx:	Drug Allergies:		Requested Length of Treatment:
Height and Weight:		Diagnosis Related to Medication Requested:	
List all medications that were trialed and failed, including dose, duration, and outcome of each therapy:			
<i>Please include Medical Record document documenting trial and outcome of each therapy indicated above</i>			
<p>** ALL CRITERIA ON CHECKLIST BELOW MUST BE MET IN ORDER FOR EXCEPTION TO BE APPROVED**</p> <p><input type="checkbox"/> Requested drug is FDA Approved</p> <p><input type="checkbox"/> There has been an adequate trial and failure of all formulary and State Carved Out medications. Attach Documentation.</p> <p><input type="checkbox"/> Member has contraindications to, or an intolerance to, formulary medications. Attach Documentation.</p> <p><input type="checkbox"/> The requested exception is considered the Standard of Care as evidenced by accepted Clinical Practice Guidelines developed by the appropriate medical specialty and supported by at least two (2) Peer-reviewed journal articles that are: randomized, double-blinded, against placebo and/or Alternative therapy. Attach Documentation.</p>			
Prescriber's Signature & Date:			

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