

Request for Medicare Part D Non Formulary, Tier or Quantity Limit Exception

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form cannot be used to request barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or weight gain, drugs for hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations).

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Diagnosis: _____ Length of Therapy: _____

Quantity: _____ Frequency: _____

Name of prescription drug you are requesting (if known, include strength, quantity and quantity requested per month): _____

Rationale for Exception Request **(FORM CAN NOT BE PROCESSED WITHOUT REQUIRED EXPLANATION)**

Alternate drug(s) contraindicated or previously tried, but with adverse outcome (eg, toxicity, allergy, or therapeutic failure)

Specify below:

- (1) Drug(s) contraindicated or tried
- (2) Adverse outcome for each
- (3) If therapeutic failure, length of therapy on each drug(s)

Complex patient with one or more chronic conditions (including, for example, psychiatric condition, diabetes) is stable on current drug(s); high risk of significant adverse clinical outcome with medication change.

Specify below:

Anticipated significant adverse clinical outcome

Medical need for different dosage form and/or higher dosage

Specify below:

- (1) Dosage form(s) and/or dosage(s) tried
- (2) Explain medical reason

Request for formulary tier exception

Specify below:

- (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug
- (2) If therapeutic failure, length of therapy on each drug and adverse outcome
- (3) If not as effective, length of therapy on each drug and outcome

Other: _____

