Exceptions Request Form (page 1 of 2)

To initiate a review for your patient for a co-payment reduction (Tier 3 to 2) or nonformulary coverage review, please fax us this completed form. Please note that the completion of this form does **not** guarantee benefit coverage. Our standard response time for a decision is 24 hours following receipt of all information needed.

If your request is urgent or if you have questions, contact us toll-free at 1 800 753-2851.

PATIENT INFORMATION

First and Last Name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Date of Birth: |__|__|/|__|__|/|__|__|__|__| Telephone: |__|__|__|-|__|__|__|-|__|__|__|__|

Medco Member ID Number: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Street Address: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

City: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| State:|__|__| Zip:|__|__|__|__|__|__|

MEDICATION (that requires a coverage review)

Drug Name and Strength:

_____

Diagnosis: _____

PRESCRIBER INFORMATION

First and Last Name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Street Address: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

City: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__| State:|__|__| Zip:|__|__|__|__|__|__|

SECURE Fax: |__|__|__| - |__|__|__| - |__|__|__|__| Telephone: |__|__|__| - |__|__|__| - |__|__|__|__|

Signature: _____ Date: _____

SECTION A: PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS

1.	☐ Yes	☐ No	Has your patient experienced INTOLERANCE or is INTOLERANCE SUSPECTED with any of the preferred alternatives?
2.	☐ Yes	☐ No	Has your patient experienced THERAPEUTIC FAILURE with any of the preferred alternatives or would failure be suspected with any of the preferred alternatives?
3.	☐ Yes	☐ No	Could transitioning this patient to therapy with a preferred alternative result in DESTABILIZATION or CLINICAL RISK to your patient?
4.	☐ Yes	☐ No	Is this patient UNABLE TO USE the preferred alternative(s) because of DOSAGE FORM?
5.	☐ Yes	☐ No	Would COMPLIANCE be at risk with the use of individual preferred agents for the treatment of the patient's condition?
6.	☐ Yes	☐ No	Are there any preferred alternative(s) that can be used to treat this patient or patient's condition?
7.	☐ Yes	☐ No	Is the use of the requested nonpreferred drug a labeled (that is, FDA labeled) indication?
8.	☐ Yes	☐ No	**If NO** to Step 7, is the nonpreferred drug being used for an indication that has efficacy supported by one or more citations included in at least one of the following compendia: the American Hospital Formulary Service Drug Information, U.S. Pharmacopeia (USP)-Drug Information, the DRUGDEX Information System, and the American Medical Association Drug Evaluations?

FAX COMPLETED FORM TO 1 800 711-5673. (Please do **not** send with a cover sheet.)

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PLEASE RE-ENTER THE FOLLOWING INFORMATION ONTO THIS PAGE
PATIENT INFORMATION

First and Last Name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Medco Member ID Number: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

MEDICATION (that requires a coverage review)

Drug Name and Strength:

____

SECTION B: PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS

1.	☐ Yes	☐ No	Is the prescriber a Medicare-participating prescriber?	
2.	☐ Yes	☐ No	Is this patient currently enrolled in Part B coverage?	
3.	☐ Yes	☐ No	☐ Unknown/ pending	Has coverage for the requested medication been sought under Part B benefit?
4.	☐ Yes	☐ No	☐ Unknown/ pending	Has coverage been denied under the Part B benefit?
5.	☐ Yes	☐ No	If YES to question 4, has Part B coverage of this medication been denied because of determination of lack of medical necessity?	
6.	☐ Yes	☐ No	If YES to question 4, has Part B coverage of this medication been denied because of member ineligibility?	

SECTION C: COMPLETE IF APPLICABLE: PATIENTS USING A NON–SELF-ADMINISTERED INJECTION

1.	☐ Yes	☐ No	Is this drug a NON–self-administered injection?
2.	☐ Yes	☐ No	Is the requested drug going to be administered in the prescriber's office or in a clinic?

SECTION D: COMPLETE IF APPLICABLE: PATIENTS USING DRUGS ADMINISTERED VIA NEBULIZER

1.	☐ Yes	☐ No	Is this patient residing in a long-term care facility?
2.	☐ Yes	☐ No	Is this drug an inhaled solution administered via nebulizer?
3.	☐ Yes	☐ No	Is the prescribed agent being used for the treatment of COPD?
4.	☐ Yes	☐ No	Is the prescribed agent being used via nebulizer in the patient's home?

SECTION E: IF APPLICABLE, PLEASE PROVIDE ADDITIONAL RATIONALE BELOW

FAX COMPLETED FORM TO 1 800 711-5673. (Please do **not** send with a cover sheet.)

Form 001-W
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