Coverage Exception Request

NOTE: This form must be completed by the prescribing physician. Because of the protected health information (PHI) contained, this form will be used only for purposes related to provision of treatment, payment and health care operations (TPO). This form and its contents are permissible under HIPAA. HIPAA does not restrict the communication of PHI to providers for TPO-related purposes.

Patient Information	Prescriber Information
Patient Name:	Prescriber Name:
Date of Birth:	Prescriber Phone Number:
Plan Participant ID Number:	Prescriber Fax Number:

Exceptions may be allowed if considered medically necessary and meet one of the following circumstances:

1. There is a medical contraindication to the use of formulary/generic medications
2. The member would likely experience significant adverse effects from the use of formulary/generic medications.
3. The use of formulary/generic medications represents an unacceptable clinical risk to the member.
4. There are no formulary alternative medications available.

A. **Medication and Dose requested**: _____

B. Diagnosis:_____ ICD-9 Code:_____

C. State the clinical rationale for the brand penalty or tiering exception request (see above criteria):

_____

_____

_____

D. Additional information pertinent to the patient's condition and request: _____

_____

_____

As the prescriber, I certify that the information provided is accurate and complete.

Prescriber Signature _____ **Date** _____

Fax completed form to
1-866-309-2734

Plan participant privacy is important to us. Our employees are trained regarding the appropriate way to handle our plan participants' private health information.

91-P2037