



NON-FORMULARY EXCEPTION REQUEST

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested _____ **Quantity** _____
 (one drug per form only) (qty. edit only)

Date _____ Patient's ID# _____

Patient's Name _____ Patient's DOB _____

Prescribing Physician _____ Office Contact _____

Office Fax# _____ Office Phone# _____

- 1. PROVIDER SPECIALTY** (specify) _____
- 2. DIAGNOSIS for Drug Requested** (specify) _____
- 3. MEDICATION HISTORY** (Please list any previous or current therapy related to the diagnosis, using drug names and dates; current therapy is therapy used by the Member within the last 30 days; for previous therapy, include beginning and end dates.)
 N/A If none or not applicable to diagnosis, indicate "N/A."

Drug	Dates and Duration (required for previous therapy)	
_____	<input type="checkbox"/> current	<input type="checkbox"/> previous _____
_____	<input type="checkbox"/> current	<input type="checkbox"/> previous _____
_____	<input type="checkbox"/> current	<input type="checkbox"/> previous _____
_____	<input type="checkbox"/> current	<input type="checkbox"/> previous _____

Please add any supporting medical information that may be useful in the decision-making process:

FAX TO 215-241-3073 OR 1-888-671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal Use Only					
Document #	_____	Processor Initials	_____	Date	_____
M	F	Rx coverage	Y	N	STANDARD - SELECT
Previous Auth	Y	N	Approved	Reviewer Initials	_____
				Date	_____