Request for Formulary Exception

This form may be used to request exceptions from the drug formulary, including drugs requiring prior authorization. *You may also ask us for a coverage determination by phone at 740.695.7914 or through our website at healthplan.org.* Please note that the prescription benefit and / or plan contract may exclude certain medications.

Member Name: _____ DOB: _____

Member ID #: _____ Date: _____

Name of prescription drug (include strength and quantity requested per month):

_____

Diagnosis Code: _____ CPT Code: _____

Reason formulary agents are not appropriate: _____

_____

Medications tried in past: _____

Risk to formulary alternatives: _____

Pertinent labs: _____

Weight: _____ Height: _____

PHYSICIAN INFORMATION

Physician Name: _____

Specialty: _____ NPI#: _____

Address: _____

Telephone#: _____ Fax#: _____

Contact Person: _____ Title: _____

Physician Signature: _____

COMPLETE THIS SECTION ONLY IF YOU ARE REQUESTING AN URGENT DECISION

If you, or your prescribing physician, believe that waiting for a standard decision (which will be provided within 72 hours) could seriously harm your life or health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician asks for a faster decision for you, or supports you in asking for one by stating (in writing or in a telephone call to us) that he or she agrees that waiting 72 hours could seriously harm your life or health or ability to regain maximum function, we will give you a decision within 24 hours. If you do not obtain your physician's support, we will decide if your health condition requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS (if you have a supporting statement from your prescriber, attach it to this request).**

*Requestor's Signature: _____ Date: _____

*Requestor's relationship to member (ex: member, family, physician, Power of Attorney):

_____

*Requestor's Phone : (_____) _____ - _____

*REQUIRED FIELD

**If the requested drug is a specialty medication and it is approved, THP Rx will notify you in the approval letter of which specialty pharmacy to use (does not apply to Medicare members).*

Member may be responsible for a copayment.
Fax requests to The Health Plan
304.885.7592, Attention: Pharmacy Service