Medical Exception Request Form

Please fax the completed request form to Mercy Health Plans'
Pharmacy Department at 314-214-8201 or 800-466-9854.
For Questions, call 314-214-8282 or 800-647-2240.

Patient Name: ______________________ Today's Date: ____/____/____

Patient Pharmacy ID: ______________________ Date of Birth: ____/____/____
(located on bottom right of pharmacy card)

Requesting Physician: ______________________ Specialty: ______________________
(Please print)

Office Contact Person: ______________________ Phone #: (______) ______-______

Office Address: ______________________

Medication Requested: ______________________ Fax #: (______) ______-______

Expected Duration of Therapy: ______________________

Diagnosis: ______________________ ICD-9: ______________________

Please list reasons why you are requesting this medication. Include previous formulary medications and/or treatments tried and why they were inadequate. Also include specifics such as side effects or other signs of treatment failure.

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Supporting Lab Values/Test Results (if relevant):

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Physician's Signature: ______________________ Date: ____/____/____

For Mercy Health Plans use only: Date Reviewed: ____/____/____

☐ Approved Length of Approval ______________________

☐ Denied Reason for Denial ______________________

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Reviewer's Signature: ______________________

Override Entered in ☐ Caremark ☐ CCMS for ________ - ________ by ______________

Office Notified on ____________; at ________ am/pm; by ________; spoke to ____________

Revised: 05/31/2005