



MEDICATION EXCEPTION REQUEST FORM

Failure to fully complete this form may result in delays in the approval process.

MEMBER INFORMATION

Member instructions: Request a formulary agent be used before completing this form. Complete this portion of the form and submit it to the prescribing physician. **PLEASE PRINT.**

Patient Name: _____ Patient Date of Birth: ____/____/____
 Patient Member ID # (on insurance card) : _____ Patient Day Phone: _____
 Patient Mailing Address: _____
 Policy Holder Name: _____ Policy Holder Employer: _____
 Medication, Dose, Frequency: _____ Expected Length of Therapy: _____
 Prescribing Physician: _____ Physician Phone #: _____
 Physician Address: _____ Physician FAX: _____

PHYSICIAN DOCUMENTATION

Physician instructions: Consult the list of Non-Formulary Drugs before completing this form.

Diagnosis: _____

There are no medications for this indication on the Formulary.

Previously unsuccessful therapeutic trials with **Formulary** drugs:
 Please include use of drug samples, prophylactic therapy for migraine, etc., if applicable.

Formulary Drug	Failed Therapy	Intolerance	Description of Problem
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other patient conditions prohibit use of a Formulary drug. (Please specify) _____

AFTER COMPLETING, SEND TO:

Pharmacotherapy Management Center
 3265 S. National, Suite 110
 Springfield, MO 65807

Phone: 417-820-3158 Fax: 417-820-8167

Physician Signature

Date

PMC USE ONLY

CAR/GRP: ____ / ____ MA DATE: ____ / ____ / ____

GC/UC: _____ DATES COV'D: _____

COMMENTS: _____

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