



**PHARMACOTHERAPY MANAGEMENT CENTER**  
 3265 S. NATIONAL, SUITE 110 • SPRINGFIELD, MO 65807  
 TOLL-FREE PHONE (855) 840-0400 • TOLL-FREE FAX (855) 840-1100  
 LOCAL PHONE (417) 820-3158 • LOCAL FAX (417) 820-8167

## 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 Specialty: \_\_\_\_\_  
 Physician Phone #: \_\_\_\_\_ Physician FAX: \_\_\_\_\_  
 Physician Address: \_\_\_\_\_

### PHYSICIAN DOCUMENTATION

**Physician instructions:** Please list reasons why you are requesting this medication. Formulary information is available at [www.mercyhealthplans.com/formulary](http://www.mercyhealthplans.com/formulary).

**Diagnosis:** \_\_\_\_\_

**Prior Treatments** (Please list other formulary medications and/or treatments tried and why they were inadequate):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Supporting Lab Values/Test Results** (if relevant):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**AFTER COMPLETING, SEND TO:**

Pharmacotherapy Management Center  
 3265 S. National, Suite 110 • Springfield, MO 65807  
**TOLL-FREE FAX: (855) 840-1100**  
**LOCAL FAX: (417) 820-8167**

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**

**PMC USE ONLY**

CAR/GRP: \_\_\_\_ / \_\_\_\_ MA DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 GC/UC: \_\_\_\_\_ DATES COV'D: \_\_\_\_\_  
 COMMENTS: \_\_\_\_\_

THIS DOCUMENT CONTAINS CONFIDENTIAL PATIENT INFORMATION THAT IS LEGALLY AND MEDICALLY PRIVILEGED. THE INFORMATION IS INTENDED ONLY FOR THE USE OF THE PHARMACOTHERAPY MANAGEMENT CENTER (PMC) AND THE OFFICE SUBMITTING THE REQUEST. IF YOU ARE NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISCLOSURE, COPYING, OR DISTRIBUTION OF THIS FORM IS STRICTLY PROHIBITED. IF YOU HAVE RECEIVED THIS FORM IN ERROR, PLEASE NOTIFY PMC IMMEDIATELY BY TELEPHONE TO ARRANGE RETURN OF THE DOCUMENT.