FORMULARY EXCEPTION REQUEST FORM

For authorization, please answer each question and fax this form PLUS chart notes back to the MHC Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance at 855-885-7695

Disclaimer: Formulary exception request forms are subject to change in accordance with Federal and State notice requirements.

Member Information	Prescriber Information
Member Name:	Prescriber Name and Specialty:
Member ID#:	Prescriber NPI#:
Member Date of Birth:	Prescriber Office Phone:
Member Phone:	Prescriber Secure Fax:
Member Drug Allergies:	Prescriber Office Contact:

Diagnosis and Medical Information

Drug Name and Strength Requested:	Diagnosis & ICD Code:
Dosing Instructions:	Quantity per 30 Days:

Questions	Yes	No
1. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐
2. The member's drug benefit plan provides coverage for other drugs which may be considered for treating your patient. Can your patient's treatment be switched to a formulary drug? If **yes,** provide your patient with a new prescription for the formulary product. Available Formulary Alternatives: See Formulary or Preferred Drug List.	☐	☐
3. Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	☐	☐
4. Does the prescribed dose and quantity fall within the FDA approved labeling or within dosing guidelines found in the compendia of current literature?	☐	☐
5. Has the member tried and had an inadequate treatment response or intolerance to all required formulary alternatives? If **yes**, then documentation is required for approval (Drug Name and Reason for Failure). **Note:** All formulary alternatives should be prescribed first unless the patient is unable to use or receive treatment with the alternative. Required Formulary Alternatives: See Formulary or Preferred Drug List (If yes, no further questions.)	☐	☐
6. Does the patient have a contraindication to all the alternatives?	☐	☐

Previous Formulary Trial(s)

Drug Name/Strength Dosage	Date(s) and Duration of Trial	Treatment Outcome

Request Rationale	
History of a medical condition, allergies or other pertinent information requiring the use of this medication: ____ ____ ____ ____ ____ ____ ____	
Prescriber Signature:	Date:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

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