ROCKY MOUNTAIN HEALTH PLANS®

RMHP Medicare Part D Formulary Exception Request
Physician Supporting Statement

Use this form to request coverage of a non-covered Part D drug

RMHP has received a request to cover the following non-formulary drug:

Fill this form out completely

Check one:

☐ Standard decision requested (72 hours)

☐ Fast decision requested (24 hours): Patient's health may be put at risk unless a decision is made within 24 hours

Member Name:	Prescribing Physician:
Member Address:	Physician Address:
Member ID#:	Phone #:
Member DOB:	Fax #:
	NPI/DEA#:

Prescription Information:

Medication Name/Dosage: _____

Directions for use and indication: _____

Intended use must be in accordance with FDA indications or supported by approved CMS Compendia.

One of the following boxes MUST BE CHECKED or this request will be denied:

☐ My patient is a candidate for a covered alternative drug

☐ Covered drugs on the RMHP Formulary would be less effective than the requested drug*

☐ Covered drugs on the RMHP Formulary would have an adverse effect compared to the requested drug*

RMHP Formulary Covered Alternatives

Drug	Formulary Tier

***If you have indicated covered alternatives are not suitable, explain medical rationale below and/or attach medical documentation.**
For approval, it must be demonstrated that at least two covered alternative drugs have been previously used and were not effective or were not tolerated.

Incomplete forms will NOT be processed and may result in denial of this request

Physician signature _____

Please FAX back to RMHP at 858-790-7100

Pharmacy Technician initials _____ Date Initiated _____