ROCKY MOUNTAIN HEALTH PLANS®
Good health. That's the plan.

RMHP Medicare Part D Formulary Tier Exception Request

Use this form to request tier 2 coverage of a tier 3 Part D drug
Use this form to request tier 1 coverage of a tier 2 Part D drug
Requests to cover tier 3 drug at tier 1 will not be approved

RMHP has received a request to cover the ____ tier drug ____________________ at _____ tier

Please fill out the following form 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:_______________________________________ Member ID# ____________________

Requesting Physician: ____

Requesting physician PHONE # _________________________ FAX #__________________________

Medication Name _______________________________________ strength________________________

Directions for use and indication ____

In order to be approved, it must be demonstrated that all lower tiered therapeutic alternative medications would be less effective or would cause harm to the patient.

Covered alternatives:

Drug	Formulary Tier

Check one:
☐ Yes, my patient is a candidate for a lower tiered therapeutic alternative medication

☐ No, my patient is NOT a candidate for a lower tiered therapeutic alternative medication

If No, please state specific medical reason patient cannot use an alternative medication:

Incomplete forms will NOT be processed.

Physician signature ____

Please FAX back to RMHP at 970-248-5034

FOR RMHP INTERNAL USE ONLY

RMHP Pharmacy Director	RMHP Medical Director
☐ Approved ☐ Denied	☐ Approved ☐ Denied
Comments:	Comments:
Signature	Signature

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