ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

RMHP Medicare Part D Formulary Tier Exception Request

Use this form to request tier 3 coverage of a tier 4 Part D drug
Requests to cover tier 2 or tier 5 drugs at a lower tier will not be approved

RMHP has received a request to cover the 4th tier ("nonpreferred brand") drug ______________________ at the 3rd tier ("preferred brand") copayment.

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:	Prescribing Physician:
Member Address:	Physician Address:
Member ID# :	Phone #:
Member DOB:	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

Pharmacy Technician initials Date Initiated

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