



RMHP Medicare Part D Formulary Exception Request

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

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

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 #:

Prescription Information:

Medication Name/Dosage: _____

Directions for use and indication: _____

In order to be approved, **documentation must be provided demonstrating that all covered 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 covered therapeutic alternative medication.
- No, my patient is NOT a candidate for a covered alternative medication

If No, please state specific medical reason and provide supporting documentation:

Incomplete forms will NOT be processed.

Physician signature _____

Please FAX back to RMHP at 970-248-5034

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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