

RMHP Medicare Part D Formulary Tier Exception Request

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

RMHP has received a request to cover the 3rd tier drug _____ at the 2nd tier 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 _____

Confidentiality Notice:

This facsimile transmission (and/or documents accompanying it) may contain confidential information. This information is intended only for the use of the individuals named above. If you have received this transmission in error, or cannot identify the recipient for distribution purposes, please notify us immediately at 970-244-7760. Plans underwritten by Rocky Mountain HMO or Rocky Mountain HealthCare Options. 02/20/09