



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 #:

Medication Name _____
 Strength _____
 Directions for use and indication _____

In order to be approved, it must be demonstrated 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:

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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