

# Formulary Exception Request Form

### Member Information

Patient Name \_\_\_\_\_  
 Cardholder ID \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_

### Provider Information

Provider Name \_\_\_\_\_  
 DEA Number \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State and Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_  
 FAX Number \_\_\_\_\_

### Pharmacy Information

Pharmacy Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

### Criteria for Approval:

1. Name of the drug requested: \_\_\_\_\_
  2. What is the diagnosis of the patient? \_\_\_\_\_
  3. The patient is unable to take the drug(s) on formulary because:
    - Adverse events
    - Contraindication
    - Drug Failure
    - Formulary drug not as effective
    - Formulary changes
    - Patient already on requested drug
    - Other: \_\_\_\_\_
4. Anticipated length of therapy: *Check One:* 30 day supply \_\_\_\_\_ Number of months \_\_\_\_\_

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

**Fax completed forms to (866) 284-4509.**

### For Office Use Only

Date/Time Received \_\_\_\_\_  
 Reference Number \_\_\_\_\_  
 Approved / Denied (Circle One) by \_\_\_\_\_ Date \_\_\_\_\_  
 Date/Time Returned to Provider \_\_\_\_\_

If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284-4492 or FAX Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management  
 3375-I Capital Circle NE  
 Tallahassee, FL 32308

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