Mandatory Mail and Maintenance Drug Network Exception Request

Note to Prescribers: Complete this form to request an exception for the patient to continue to receive 30 days' supply of a maintenance medication, including psychotropic medications, at a network retail pharmacy

Patient Information		
Patient Name:		
Date of Birth:		
Plan Member ID Number:		
Prescriber Information		
Prescriber Name:		
Prescriber Phone Number:		
Prescriber Fax Number:		
The following sections to be completed by the prescriber. *(Incomplete or missing information may delay processing and result in the form being returned to the requester.)*		
Drug Name:		
Strength:	Dosage Form:	Diagnosis:

1.	Is the patient a resident of a nursing home or skilled residence facility? If so, verify with an accompanying signed prescriber statement.
2.	Is the patient subject to safety concerns if he/she receives an increased quantity of medication (up to 3x retail limit)?
3.	Is the patient receiving a maintenance medication for the treatment of an acute condition?
4.	Is the patient's medication currently being titrated by the prescriber? If yes, please document condition.
5.	Is the patient less than 18 years old and receiving a maintenance medication?

As the prescriber for the brand-name drug above, I certify that the information provided is accurate and complete.

Prescriber Signature:_____ Date:_____

Fax the completed form to the Exceptions Department at 1-888-487-9257.

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