

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 |
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| 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: |
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| Is the patient a resident of a nursing home or skilled residence facility? If so, verify with an accompanying signed prescriber statement. |
| 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? |
| 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: Date: Fax the completed form to the Exceptions Department at 1-888-487-9257. |

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