

## 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:
<b>The following sections to be completed by the prescriber.</b> (Incomplete or missing information may delay processing and result in the form being returned to the requester.)
Drug Name:
Strength: Dosage Form: Diagnosis:
<ol> <li>Is the patient a resident of a nursing home or skilled residence facility? If so, verify with an accompanying signed prescriber statement.</li> </ol>
<ol> <li>Is the patient subject to safety concerns if he/she receives an increased quantity of medication (up to 3x retail limit)?</li> </ol>
3. Is the patient receiving a maintenance medication for the treatment of an acute condition?
<ol> <li>Is the patient's medication currently being titrated by the prescriber? If yes, please document condition.</li> </ol>
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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