CVS CAREMARK

Brand Penalty Exception Request

Complete this form to request an exception for a patient to receive a brand-name drug instead of a generic alternative and pay only the appropriate brand copayment.

Patient Information	**Prescriber Information**
Patient Name:	Prescriber Name:
Date of Birth:	Prescriber Phone Number:
Plan Member ID Number:	Prescriber Fax Number:

NOTE: The following sections must be completed by the prescriber.
Incomplete or missing information may delay processing and result in the form being returned to the requestor.

Brand Drug Name:	Strength:
Dosage Form:	Diagnosis:

Please answer each of the following questions:

1. Has the patient experienced an inadequate treatment response (tried and failed) with the generic alternative?

2. Has the prescriber determined that the generic alternative is not appropriate based on a specific clinical concern (i.e. allergy)? If yes, please document.

3. Has the patient been stabilized on a brand name medication for a specific clinical condition (i.e. fragile epilepsy, transplant immunosuppression, etc.)? If yes, please document.

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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