CVS/caremark™

Tiering Exception Request

Complete this form to request an exception for the patient to receive the non-formulary medication at the formulary brand copay.

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.)*		
Non-Formulary Brand Drug Name:		
Strength:	Dosage Form:	Diagnosis:
1. Does the patient have a documented contraindication to, or a potential drug interaction with, the formulary alternatives?		
2. Is the patient intolerant to, or had a confirmed adverse event with, the formulary alternatives?		
3. Has the patient experienced an inadequate treatment response with **TWO** formulary alternatives?		
4. Has the prescriber determined that the formulary medication is not appropriate based on a specific clinical concern not listed above? 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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