GATEWAY HEALTH PLAN *MEDICARE ASSURED® HMO SNP*
DRUG EXCEPTION FORM

Please use this form to request coverage of a nonformulary drug or quantity limit for an **individual** patient. This form may be copied for office use. To request coverage of a drug that requires a prior authorization or step therapy, please use the drug specific prior authorization or step therapy form available on the website at www.gatewayhealthplan.com.

Complete all of the information requested and **FAX THE FORM TO (888) 447-4369.**

- Gateway will contact the MD if additional clinical information is needed.
- If the request is denied, the MD can change the prescription to an appropriate formulary alternative or file an appeal with Gateway.

Member ID#: _____

Member Name: _____ Date of Birth: _____

Pharmacy Name: _____ Pharmacy Phone: _____

DRUG NAME: _____

DOSAGE/FREQUENCY: _____

DIAGNOSIS FOR WHICH ABOVE DRUG IS PRESCRIBED: _____

_____

You must be able to document the ineffectiveness of formulary alternatives or the reasonable expectation of adverse reactions from the use of formulary products for a request to be approved. Please document formulary alternatives previously used and the clinical rationale for the requested drug in the space below. Additional pages of clinical information, such as laboratory results, may be faxed with this form.

FORMULARY ALTERNATIVES THAT HAVE BEEN USED BY THE PATIENT

Drug Name	Strength	Dates Used	Documentation of failure of therapy

Additional Clinical Information:

_____

_____

_____

_____

PHYSICIAN NAME (Printed): _____ PHONE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

Could the member's health be seriously harmed by waiting three days for a decision on this request?

- ❑ Yes, then please call 1-800-685-5215 for an expedited review.
- ❑ No