



NON-FORMULARY DRUG EXCEPTION FORM

The DRUG SPECIFIC PRIOR AUTHORIZATION and STEP THERAPY FORMS are available on the website at www.gatewayhealthplan.com. If you need to speak to a Pharmacy Services Representative, call 1-800-528-6738.

FAX COMPLETED FORM TO: (888) 245- 2049

SECTION A - MEMBER INFORMATION

First name:	Last name:	Date of Birth:	Member ID:
Allergies:	Type of reaction(s):		

SECTION B - PHARMACY INFORMATION

Pharmacy Name:	Pharmacy Phone Number:
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SECTION C - CLINICAL INFORMATION

Drug Name Requested:	Dosage and Frequency:	Quantity:	Length of therapy:
Diagnosis for which drug is being requested:			

FORMULARY ALTERNATIVES THAT HAVE BEEN USED BY THE PATIENT

You must be able to document the therapeutic failure or contraindication to formulary products for a request to be approved.

Drug Name/ Strength	Dates Tried:	Reason therapy failed or discontinued
Is member currently or recently hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>	Date of Discharge:	Reason for Hospitalization:

Additional Clinical or Supporting Information: *Please include current office notes, lab data, and other supporting medical literature.*

SECTION D - PRESCRIBER INFORMATION

Prescriber Name (printed):	Prescriber Specialty:	NPI Number:
Office Phone:	Office Fax:	
Prescriber Signature:	Date:	

If the request is denied, the prescriber can change the prescription to an appropriate formulary alternative or with written member consent file an appeal with Gateway. The Drug Formulary is available on the website at www.gatewayhealthplan.com.

