GATEWAY HEALTH PLAN® DRUG EXCEPTION FORM

Please use this form to request coverage of a nonformulary drug, quantity limit or step therapy exception for an **individual** patient. This form may be copied for office use.
Complete all of the information requested and **FAX THIS FORM TO (412) 255-4544 or (888) 245-2049.**

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

MEMBER ID#:_____
Member name: _____ Date of Birth: _____
PHARMACY NAME: _____ Pharmacy Phone:_____

DRUG NAME: _____
DOSAGE/FREQUENCY: _____
NEW OR ONGOING PRESCRIPTION: ☐ NEW ☐ ONGOING
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: _____