DisclosedRx
The Fiduciary and Fully Disclosed PBM®

PO Box 701
Washington, IN 47501
Phone: 480-561-6005
Fax: 602-585-0588

Formulary Exception Request Form

This form should only be submitted for medications excluded from the formulary.
Requests will not be accepted if the exclusion is based on plan design rather than formulary status.

☐ **Standard** ☐ **Urgent**

Patient Information

Patient Name: _____ **DOB (mm/dd/yyyy):** _____ **Gender:** _____

Address: _____ **City:** _____ **State & Zip:** _____

Cardholder ID: _____ **Group #:** _____ **Relationship Code:** _____

Phone Number: _____ **Email address:** _____

Prescriber Information

Prescriber Name: _____ **Specialty:** _____ **NPI:** _____

Address: _____ **City:** _____ **State & Zip:** _____

Office Contact: _____ **Phone Number:** _____ **Fax Number:** _____

Medication Information

Drug Name: _____ **Strength:** _____ **Quantity:** _____

Directions: _____ **Day Supply:** _____

Indicate Request Type: ☐ **New Start** ☐ **Renewal** **Therapy Start Date (if applicable):** _____

Diagnosis: _____ **ICD 10 Code:** _____

Formulary Exception Request Information

*****Supporting documentation (i.e., chart notes, labs, etc.) must be attached to avoid processing delays*****

1. **Is the requested agent being used for an FDA approved indication?** ☐ **Yes** ☐ **No**
2. **Is the requested agent dosed appropriately for an FDA approved indication?** ☐ **Yes** ☐ **No**
3. **Is the requested agent being prescribed by or in consultation with an appropriate specialist (if applicable)?** ☐ **Yes** ☐ **No**
4. **Does the patient have any FDA contraindications to the requested agent?** ☐ **Yes** ☐ **No**
5. **For renewal requests: Has the patient had a positive clinical response to therapy? Must submit objective documentation.** ☐ **Yes** ☐ **No**
6. **Formulary exceptions require ALL preferred alternatives to be tried and failed prior to coverage. Please list all of the medications that have been previously used to treat this diagnosis or are contraindicated for this patient. Please include medication names, strengths, dosage forms, trial dates, and outcome.**
   - For any nonsolid oral dosage formulation: the provider must submit documentation of medical necessity for why patient cannot be changed to a solid oral dosage formulation
   - For excluded extended-release formulations: the provider must submit documentation of an inadequate clinical response with its immediate release formulation (if available)
   - For excluded brand names that have preferred generics: the provider must submit documentation of an inadequate clinical response or allergy to two or more generic labelers (if available)

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7. Please provide any additional supporting documentation that should be reviewed (attached or provided below):

Additional Comments:

Prescriber Signature: _____ **Date:** _____

Authorized Agent's Name: _____

Please fax this request to 602-585-0588 or our secure email at care@disclosedrx.com
Mail Requests to: DisclosedRx Clinical Team
PO Box 701 Washington, IN 47501