



Formulary Tier Exception Member Request Form

Send completed form to:
Service Benefit Plan
Attn: Reconsideration
P.O. Box 52080
Phoenix, AZ 85072-2080
FAX: 1-800-273-5357

CARDHOLDER OR PHYSICIAN COMPLETES

If you are requesting a copay exception for more than one medication, please use a separate form for each medication.

Date: ____/____/____

Patient Name: _____
First MI Last

Patient Address _____
Street Address City State Zip

Patient Date of Birth: ____/____/____ Sex: M____F____ R

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Cardholder Identification Number

PLEASE NOTE: If approved, claims processed prior to approval date will not be adjusted as the copay on previous fills was correct based on the plan benefit.

STANDARD OPTION/BASIC OPTION MEDICARE B PRIMARY MEMBERS ONLY: If approved, your exception override will be applied either to the retail pharmacy **OR** the mail service pharmacy – please indicate where you would like to obtain your medication.
 Retail Pharmacy Mail Service Pharmacy

PHYSICIAN ONLY COMPLETES

All fields below must be completed to begin processing the Formulary Tier Exception request.

Patient's Diagnosis: _____

Brand-Name Drug copay request for (please specify drug name): _____

Please specify Dosing Directions: _____

Indicate the outcome that best describes your patient's experience with all drugs in this therapeutic class:

Therapeutic Failure(s) with generic and/or brand medications in this therapeutic class.

1) Indicate ALL the drug name(s) the patient has failed on in this class: _____

2) Describe the therapeutic failure(s): _____

Adverse Event(s) with generic and/or brand medications in this therapeutic class.

1) Indicate ALL the drug name(s) the patient has had an adverse event within this class: _____

2) Describe the adverse event(s): _____

Physician Name (Print Clearly) (_____) Phone (_____) Fax

Street Address City State Zip

Prescriber's NPI Physician Signature / / Date

Prescriber Certification: I certify that I am the physician and all information provided on this form to be true and correct to the best of my knowledge and belief.