Formulary Exception Request

Depending on the nature of your request, Pharmacy Services may need to obtain additional information. If the therapy requested is not well established, references are helpful. The completeness of the information you provide has an impact on how quickly your request can be considered.
Thank you

Send the requested info to GHC Pharmacy Benefits at:
Fax- 608.828.4810
Phone- 608.828.4811

Confidential

WHO-WHAT-WHEN		
Name of requesting practitioner: and **NPI #:**	**Practitioner's #'s** Ph: Fax: Contact Name:	**Practitioner location** (e.g. Capitol clinic, Wingra, UWHC)
Patient Name:	**Patient's GHC Member #:**	**Patient's DOB**:
Name of drug you are requesting insurance coverage for:	**Date of request:**	

REASON (Please check one and provide requested information)	
Formulary Drugs have been Tried and Failed due to: ☐Therapeutic Failure ☐Adverse Effects ☐Other	**Patient's Diagnosis:**
Reason/Explanation for Request :	**Please list Patient's Medication History, and indicate the results, including dosage and duration of therapy.**

***** FOR GHC-SCW PHARMACY ADMINISTRATION ONLY *****		
Database ID #:	Reviewer Initial:	**Urgent Request** (w/in 1 business day): ◊ **Yes** ◊ No **Decision**: ◊ Approved ◊ Denied ◊ Withdrawn
Coverage Model: ◊ Staff ◊ Non-Staff ◊ Wrap ◊ PPO	Internal Review By:	**Decision Made By:**
Federal Plan Holder? ◊ Yes ◊ No	MA/Badgercare: ◊ Yes ◊ No Navitus: ◊ Yes ◊ No	**Date Decision Reached:**