Request for Formulary Exception

This form may be used to request exceptions from the drug formulary, including drugs requiring prior authorization. Please note that your prescription drug rider and / or plan contract may exclude certain medications.

Member name: ____________________________ Date of birth: _________________

Member ID number: _______________________

Requestor's relationship to member (must have power of attorney):
____

Member or requestor's street address: ____

City: ______________________ State: ______ Zip: _________

Phone: Phone: (_____) ______ - ________

Name of prescription drug you are requesting:
____
(if known, include strength, quantity and quantity requested per month)

Reason you are requesting: ____
____

Prescriber name: ____________________________ Medical Specialty:
____

Address: ____

City: ______________________ State: ______ Zip: _________

Phone: (_____) ______ - ________ Fax: (_____) ______ - ________

Office Contact Person: ______________________

Please mail or fax Formulary Exception Request to:
The Health Plan of the Upper Ohio Valley
52160 National Road East
St.Clairsville, OH 43950
Fax: 1.888.329.8471 Attn: Pharmacy Department

The Health Plan will contact the prescribing physician on your behalf to provide a statement supporting your request within two business days. Once we receive the necessary information from your physician, you will be notified of the results within two business days.