



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 member's 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

Once The Health Plan receives the necessary information from your office, you will be notified of the results within two business days.