Medical Exception Request Form

Please fax the completed request form to the Coventry Health Care Pharmacy Department at 877-815-8751. For Questions, call 800-647-2240.

Patient Name: ________________________________ Today's Date: ________/________/________

Patient Pharmacy ID: ____________________________ Date of Birth: ________/________/________
(located on bottom right of pharmacy card)

Requesting Physician: ________________________________ Specialty: ____________________________
(Please print)

Office Contact Person: ________________________________ Phone #: (________) ________-________

Office Address: ____

Medication Requested: ________________________________ Fax #: (________) ________-________

Expected Duration of Therapy: ____

Diagnosis: ____ ICD-9: ____________________________

Please list reasons why you are requesting this medication. Include previous formulary medications and/or treatments tried and why they were inadequate. Also include specifics such as side effects or other signs of treatment failure.

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Supporting Lab Values/Test Results (if relevant):

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Physician's Signature: ____ Date: _____/________/_____

For Mercy Health Plans use only: Date Reviewed: ________/________/________

☐ Approved Length of Approval ____

☐ Denied Reason for Denial____

____

Reviewer's Signature: ____

Override Entered in ☐Caremark ☐CCMS for __________ - __________ by ____________________

Office Notified on ______________; at __________ am/pm; by _________; spoke to ______________

Revised: 05/31/2005; Updated: 05/01/2011