URx Plan Exception Request
Phone: (888) 527-5879
Fax: 406-513-1928
3404 Cooney Drive
Helena, MT 59602

Plan Exception Request**

*Please fax completed request to **(406)513-1928***

Provider Information			Patient Information		
Provider Name:			Patient Name:		
Specialty:	DEA OR TIN:		Policy Holder's Employer:		
Office contact:			ID number:		
Office phone: Office Fax:			Date of Birth:		
May we fax our response to your office? Yes No			Patient Street Address:		
Office street address:			City	State	Zip
City	State	Zip	Patient's phone number:		

Medication Requested

Name of Drug: Strength: Dosage:

Quantity prescribed per month: Expected duration of therapy:

Clinical Data:

Diagnosis related to medication use AND please attach case notes specific to the request

***Please note: any plan exception forms without related case notes attached will be declined**

Reason for Copay Reduction/Tier Exception request: (please check all that apply)

☐ The patient has a contraindication to preferred brand alternative medications
Medications that are contraindicated for this patient:

Please specify the contraindication:

☐ The patient has failed or been intolerant to prior therapy with preferred tier alternatives medications
Medications previously used, dosages and dates:

☐ Other: (please specify reason, attach additional sheet if necessary)

Physician's Signature (not valid unless signed)_____

****Please note: copay exceptions are not made for B or C tier medications**