

Date/Time of Request: Date: \_\_\_\_\_ Time: \_\_\_\_\_

### PHYSICIAN CERTIFICATION TIERING EXCEPTION REQUEST FORM

Please fill out the following information and return to us as indicated below:

<b>A. - Member Information:</b>									
Patient Name:		Plan Name/Plan ID:							
Patient ID:		Patient Date of Birth:	Patient Contact Phone#:						
<b>B. - Physician Information</b>									
Physician Name:		Physician Address:							
Physician DEA #:		Physician Phone #:	Physician Fax Number:						
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC#:						
<b>C. - Pharmacy Information</b>									
Pharmacy Name:	NABP #:	Pharmacy Phone Number:	Pharmacy Fax Number:						
<b>D. - Clinical Information: Please fill out the following clinical information:</b>									
Diagnosis/Indication			ICD-9 Code (if available)						
<p>1. Medical Justification for <u>Tiering Exception</u>:</p> <p><input type="checkbox"/> The medication is medical necessary for this patient</p> <p><input type="checkbox"/> Preferred options would be hazardous to use</p> <p><input type="checkbox"/> Preferred options have been tried and have caused undesirable side effects or have been insufficiently effective</p> <p>2. Duration of Treatment: _____</p> <p>3. Has patient taken this in the past? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>4. If yes, for how long: _____</p> <p>5. Please list other medications attempted for this patient</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Medication: _____</td> <td style="width: 50%;">Reason therapy failed: _____</td> </tr> <tr> <td>Medication: _____</td> <td>Reason therapy failed: _____</td> </tr> <tr> <td>Medication: _____</td> <td>Reason therapy failed: _____</td> </tr> </table>				Medication: _____	Reason therapy failed: _____	Medication: _____	Reason therapy failed: _____	Medication: _____	Reason therapy failed: _____
Medication: _____	Reason therapy failed: _____								
Medication: _____	Reason therapy failed: _____								
Medication: _____	Reason therapy failed: _____								
<b>Authorized Medical Signature:</b>									
<b>Telephone #:</b>		<b>Date:</b>							

**When Completed Return To:** ProCare PBM Clinical Division 3090 Premiere Parkway Ste 100 Duluth, GA 30097  
**1-866-965-Drug (3784) / Fax # 866-999-7736**

Receipt Date/Time of Completed Request: _____		<u>FOR INTERNAL USE ONLY</u>		Ticket Number: _____	
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied	(Date/Time)	Member Contacted: _____		
Reviewed by: _____	Effective Date: _____	MD Contacted: _____			
Review Date: _____	Termination Date: _____	Pharmacy Contacted: _____			
Review Time: _____					