



# Drug Formulary Exception Request

The Health Plan will review any requests for a drug that is not covered on a drug formulary. A drug formulary exception request may be initiated by a member, prescriber or a member’s designated representative. Documentation must be submitted to support this drug formulary exception request. Requests that are subject to preauthorization may require additional information. Decisions are based on eligibility, benefit determination and medical necessity. Please complete this form in its entirety.

Member name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Member ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber Office/Facility Name: \_\_\_\_\_

Prescriber Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_ Prescriber Fax Number: ( \_\_\_\_\_ ) \_\_\_\_\_

Requested start date of formulary exception: \_\_\_\_\_ Expected Length of Therapy \_\_\_\_\_

**Please complete the following:**

**Request Type:**  Standard Request (decision within 72 hours)  Expedited\*Exception Request (decision within 24 hours)  
\*pursuant to 45 CFR §156.122(c)(2)(ii).

| Drug Name | Diagnosis (if known) | Dose & Schedule |
|-----------|----------------------|-----------------|
|           |                      |                 |
|           |                      |                 |

**Previous drugs tried, if applicable (doses & dates not needed):**

**Additional information that we should consider:** \_\_\_\_\_  
\_\_\_\_\_

**For prescribers only. Determination of medical necessity requires the submission of documentation.**

- Clinical documentation is available in the Avera electronic medical record for review. Please list date(s) of pertinent records: \_\_\_\_\_
- Clinical documentation is not available in the Avera electronic medical record for review. Pertinent clinical records for the previous 12 months are attached for review.

**Requestor Information**

Requestor is:  Member  Prescriber  Member’s Designated Representative

Requestor Name: \_\_\_\_\_ Today’s Date: \_\_\_\_\_

Relationship to Member: \_\_\_\_\_ Requestor Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

**Final determination will be faxed to the prescriber. Final determination will be mailed to the member.**

**IMPORTANT NOTICE:** This determination does not guarantee benefits or payment of services. Payment of services is subject to patient eligibility at the time of treatment, benefit plan limitations and the other terms of the benefit plan. Payment of benefits is only made for services deemed medically necessary and appropriate. The final payment decision will be made upon submission of a claim to Avera Health Plans. If you have questions about your benefits, please contact Avera Health Plans Service Center at 605-322-4545 or toll-free at 1-888-322-2115. This form is not all-inclusive of services requiring preauthorization. Refer to patient’s Certificate of Coverage, Master Contract or Summary Plan Document for more information.

Fax this completed form to Avera Health Plans at **1-800-269-8561** or send secure email to [Pharmacy@AveraHealthPlans.com](mailto:Pharmacy@AveraHealthPlans.com).

This form can also be mailed to us:  
Address: 5300 S. Broadband Ln.  
Sioux Falls, SD 57108-2221