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. Incomplete forms may be returned to sender for additional information.

Member name: _____ Date of Birth: _____

Member ID Number: _____ Group Number: _____

Prescriber Name: _____ NPI number of administering facility: _____

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 DAKOTACARE. If you have questions about your benefits, please contact DAKOTACARE Customer Care team at 605-334-4000 or toll-free at 1-800-658-5508. 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 DAKOTACARE at **1-605-274-3279** or send secure email to Pharmacy@DAKOTACARE.com.

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