UCLA Health | Medicare ADVANTAGE PLAN

Exceptions Request Form

Fax: **1(858) 790-6060** Telephone: **1 (800) 926-3841**

PLEASE TYPE ANSWERS FOR BETTER CLARITY

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information

Select Priority: ☐ Routine (decision within 72 hours) ☐ Retro (Must be submitted within 30 calendar days of date of service)

☐ Urgent Priority (decision within 24 hours) check only if Member's life, health, or ability to attain, maintain, or regain max function is in serious jeopardy.

Exceptions Request: ☐ Formulary Exception ☐ Tiering Exception

PATIENT	REQUESTING PROVIDER
Name:	☐ Primary Care Provider ☐ Specialist ☐ Vendor/Ancillary
Member ID#: Date of Birth:*	Name:
Telephone:	Telephone: Fax:
Address:	Contact Name:
	Address:

Drug(s) Requested:	Quantity:	Requested approval time (max 1 year):
Strength:	Directions:	

Diagnosis: Please list all diagnoses being treated with the requested drug and or corresponding ICD-10 codes.

Is this a new therapy? ☐ Yes ☐ No. If No, please list timeframe member has been on this drug

Drug History: (List any drugs the member has previously tried for the same condition as the required drug, or provide reasons why they can not take them.)

Drugs Tried	Dates patient was on drug	Reason why drug can not be used

Additional information: Please list any additonal information/explanation/or rationale for request:

Provider Signature:	Date