Request for Formulary Exception

This form may be used to request exceptions from the drug formulary, including drugs requiring prior authorization. Please note that your prescription drug rider and/or plan contract may exclude certain medications.

Member name: Date of birth:

Member ID number:

Requestor's name (if not member):

Requestor's relationship to member (attach documentation to show authority to represent the member):

Member or requestor's street address:

City: State: Zip: Phone:

Name of prescription drug you are requesting

(if known, include strength, quantity and quantity requested per month):

Reason you are requesting:

Additional information (attach any supporting documents):

Prescribing physician's information

Prescriber name: Medical specialty:

Address: City: State: Z ip:

Phone: Fax: Office contact person:

Independent Health will contact the prescribing physician on your behalf to provide a statement supporting your request within two business days. Once we receive the necessary information from your physician, you will be notified of the results within two business days.

Please complete this form and e-mail it as an attachment to Pharmacy_Exceptions@independenthealth.com. You may also print and fax this form to (716) 631-9636, or mail it to: Independent Health, 511 Farber Lakes Drive, Buffalo, NY 14221, Attn: Pharmacy Department.

Member/Requestor's Signature Date