LifeWise Health Plan of Washington
PO Box 327, MS432
Seattle, WA 98111-0327

Pharmacy Exception Request Form

Please fax this back to Pharmacy Services

Fax Number	Phone Number
1-888-260-9836	1-800-592-6804

Member Information:

Member's Name _____ Date of Birth _____

Member's Address _____

City _____ State _____ Zip Code _____

Phone _____ Member ID # _____

Prescriber Information:

Prescriber Name _____

Address _____

City _____ State _____ Zip Code _____

Office Phone _____ Office Fax _____

Prescriber's Signature _____ **Date** _____

Medication and Diagnosis Information		
Medication (name and strength)	Diagnosis (ICD-10)	Quantity
New Prescription OR Date Therapy Initiated	Expected Length of Therapy	Drug Allergies

Medical Necessity for Brand Name Contraceptives

☐ By checking this box you are certifying that a brand name contraceptive is medically necessary.

Request for Expedited Review
(Determination within 24 hours)

Exigent circumstance: Applies to exception requests when a patient is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function.

☐ By checking this box and signing below, you are certifying that this is an expedited request due to an exigent circumstance and that the 72-hour standard review time may seriously jeopardize the life or health of the member or the member's ability to regain maximum function. The request will not be handled as an expedited request unless the box is checked and prescriber's signature is included.

Type of Request (select all that apply)
☐ Member needs a drug that is not on the plan's list of covered drugs. ☐ Requesting an exception to the requirement that member tries another drug before member gets the drug prescribed. ☐ Requesting an exception to the plan's limit on the allowed amount (quantity limit) a member can receive. ☐ Requesting an exception to use a drug or biologic agent for an off-label indication.
***NOTE: The prescriber MUST provide a statement supporting the exception request. Requests that are subject to prior authorization (or any other utilization management requirement) may require supporting information.**
****CHART NOTES ARE REQUIRED****

Clinical Rationale for the Exception Request (select all the apply)
☐ **Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure** [Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s)] ☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** [Specify below: Anticipated significant adverse clinical outcome] ☐ **Medical need for different and/or higher dosage** [Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason] ☐ **Off-label use is supported by medical compendia, scientific evidence, or approved via Emergency Use Authorization** (explain below) ☐ **Other** (explain below) **Required Explanation**

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