



# Dean Health Plan, Inc.

## Exception Request Form

(For Members Use)

Patient Name
Address
City, State, Zip

Member #	Person Code	
Group Number	Plan Type	Sex M <input type="checkbox"/> F <input type="checkbox"/>
Date of Birth		

MD Name (please print)
Clinic Name/ Mailstop
Address
City, State, Zip

MD Telephone #	Date
MD Fax #	
Physician Signature (if Physician is initiating the request)	

**You or your Physician May Fill Out This Section**

Drug Name	Strength	Directions for Use	Quantity
<b>Diagnosis for which drug is prescribed</b>			
Describe the clinical condition that relates to the drug requested. <b>List all medications</b> used to treat this condition, the dosage, the dates given, and the outcome:	<input type="checkbox"/> New Therapy	<input type="checkbox"/> Continuing	Estimated Duration of Therapy
DATA INTAKE FORMS are available for most prior authorized drugs. ALL the information on the data intake forms must be included with the prior authorization request			

(Do Not Write in the Space Below)

Approved—Effective Date: \_\_\_\_\_ Expiration date: \_\_\_\_\_

- Denied:
- Exceeds benefit limitations
  - Not a covered benefit
  - Doesn't meet medical need criteria: \_\_\_\_\_
  - Explanation: \_\_\_\_\_
  - Other: \_\_\_\_\_
  - Redirected to Formulary Alternatives such as: \_\_\_\_\_
  - Comments: \_\_\_\_\_

- Quantity is limited to: \_\_\_\_\_ capsules/tablets per copay.
- DHP's criteria for this medication is included for physician review.

Date: \_\_\_\_\_ Authorized Signature: \_\_\_\_\_

**Send to: Navitus Health Solutions**  
**999 Fourier Dr, Suite 301**  
**Madison, WI 53717**  
**Fax: 608-827-7535**

For questions, contact the Customer Service Department,  
 (608) 828-1301, or 1-800-279-1301.