



DRUG MEDICAL EXCEPTION REQUEST

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
DATE:	PRESCRIBER FIRST & LAST NAME:
PATIENT FIRST & LAST NAME:	PRESCRIBER NPI:
PATIENT ADDRESS:	PRESCRIBER MAILING ADDRESS:
PATIENT ID:	PRESCRIBER PHONE:
PATIENT BIRTH DATE:	PRESCRIBER FAX:

STEP 2: INDICATE MEDICATION REQUESTED			
REQUESTED DRUG	STRENGTH	DOSE	INDICATION

REASON FOR REQUEST:	QUANTITY LIMIT <input type="checkbox"/>	GENDER <input type="checkbox"/>
	NEW DRUG <input type="checkbox"/>	NOT COVERED <input type="checkbox"/>

STEP 3: PROVIDE DETAILS REGARDING <u>ALL</u> FORMULARY ALTERNATIVES TRIED.				
***FAILURE OF <u>ALL</u> FORMULARY ALTERNATIVES IS REQUIRED FOR APPROVAL.				
FORMULARY ALTERNATIVE NAME (S)	MAX DOSE USED	FREQUENCY OF DOSING	START AND END DATES OF TRIAL	DESCRIBE SPECIFIC AND SIGNIFICANT SIDE EFFECTS AND/OR INEFFECTIVENESS

STEP 4: SUBMISSION. COMPLETE AND FAX TO: NAVITUS PRIOR AUTHORIZATION 920-735-5350
PRESCRIBER SIGNATURE:
FOR QUESTIONS: DEAN CUSTOMER SERVICE 1-800-279-1301 OR WWW.DEANCARE.COM
IF PATIENT MEETS CRITERIA- ALLOW 2 BUSINESS DAYS FOR PROCESSING
IF CRITERIA NOT MET- SUBMIT CHART DOCUMENTATION WITH FORM CITING COMPLEX MEDICAL CIRCUMSTANCES.
IF APPROVED, COVERAGE ALLOWED FOR: ONE YEAR SUBJECT TO FORMULARY CHANGES.