Supporting Information for an Exception Request or Prior Authorization FORMULARY and TIERING EXCEPTION requests cannot be processed without a prescriber's supporting statement. PRIOR AUTHORIZATION requests may require supporting information. REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. **Prescriber's Information** Name _____ Address City ______ State ____ Zip Code _____ Office Phone_____ Fax _____ Prescriber's Signature Date Diagnosis and Medical Information Strength and Route of Administration: Medication: Frequency: New Prescription OR Date Expected Length of Therapy: Quantity: Therapy Initiated: Height/Weight: Drug Allergies: Diagnosis: Rationale for Request ☐ 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 dosage form and/or higher dosage [Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason] ☐ Request for formulary tier exception [Specify below: (1) Formulary or preferred drugs contraindicated or tried and failed, or tried and not as effective as requested drug; (2) if therapeutic failure, length of therapy on each drug and adverse outcome; (3) if not as effective. length of therapy on each drug and outcome] ☐ **Other** (explain below)

CareSource is an HMO with a Medicare contract. Enrollment in CareSource Advantage or CareSource Advantage Plus depends on contract renewal.

Required Explanation: