Pharmacy Exception to Benefit Request Form

Who is the Exception to Benefit for? *Please provide member ID#, Name, DOB, address	
Who is requesting the Exception to Benefit? *Name and contact information (If different than above)	
What drug is being requested? *Please provide drug name, strength, duration, quantity, sig, and diagnosis	
Phone:	**Fax (if applicable):**
Check the box if medication is a continuation of treatment: ☐ **Check the box if brand-name medication is being requested:** ☐ **Check the box if medication is buy & bill:** ☐	
If the member has tried and failed any treatments, please provide in detail treatment regimens that have been tried and failed.	
Briefly describe why medications on the formulary are not alternative options to the non-formulary medication. (you may attach additional information such as a physician's letter, medical records, or other documents to support your claim):	

Please refer to fridayhealthplans.com for our formulary medications. Failure to provide clinical documentation may result in the delay or denial of your request.

Send this form, your denial notice, and any supporting documentation to:

Friday Health Plans ATTN: Appeals and Grievances
700 Main St.
Alamosa, CO 81101
Phone: 1-800-475-8466 Fax: 1-844-280-1794
Email: appeals@fridayhealthplans.com

Be sure to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.