

MINNESOTA UNIFORM FORMULARY EXCEPTION FORM

INSTRUCTIONS

**Important: Please read all instructions and information before completing the form.
Please follow the directions carefully.**

This form is available at the Minnesota Department of Health's website at www.health.state.mn.us/asa and may be made available on websites of group purchasers. This form will not change frequently. The form version number and most recent revision date are displayed in the lower right hand corner.

Statutory requirements

This Minnesota Uniform Formulary Exception Form is made available pursuant to 2009 Minnesota Session Laws, Chapter 79, Article 4, Sec. 5.

This form is the single form to be used by health care providers to request exceptions from group purchaser (payer) formularies. All health care providers must submit requests for formulary exceptions using this form, and all group purchasers must accept this form from health care providers. Group purchasers may request additional information or clarification to ensure that formulary exception requests are processed as accurately and efficiently as possible. Group purchasers are also encouraged to respond to the formulary exception request using Section G of the form below. Group purchasers may supply additional instructions or other relevant or legally required information with their response.

The form initially may be exchanged via facsimile or other means. However, no later than January 1, 2011, this uniform formulary exception form must be accessible and submitted by health care providers, and accepted and processed by group purchasers, through secure electronic transmissions. Facsimile will not be considered a secure electronic transmission after January 1, 2011.

The term "health care provider" is defined in Minnesota Statutes, section 62J.03, subd. 8; the term "group purchaser" is defined in Minnesota Statutes, section 62J.03, subd. 6 (see <https://www.revisor.leg.state.mn.us/statutes/?id=62J.03>.)

Definitions and instructions

- Requests for exceptions from group purchaser formularies are requests to make nonformulary prescription drugs available to a patient as a formulary drug.
- This form is not intended for prescription drug prior authorization requests or other purposes.
- The form is provided in a Portable Document Format (.pdf) that can be completed electronically. The form should be completed electronically rather than by handwriting to ensure legibility. All needed fields must be completed or the form may be returned.
- Sections A-F are to be completed by health care provider. Note: Group purchasers making this form available on their websites may pre-populate Section A. Section G is to be completed by the group purchaser in response to the request.
- For Section B, "Patient Information": If the patient has pharmacy benefits that are separate or "carved out" from the health plan benefits, provide the patient's pharmacy benefit card ID number (the "cardholder ID"). If the patient's pharmacy benefits are integrated with the health plan coverage (if there is no separate pharmacy benefit ID number), provide the patient's health plan ID number.
- Sections D and F, medication "strength" is usually expressed in milligrams, e.g., 30 mg, 15 mg/ml, etc. Medication "dosing schedule" is used to report how often the patient will take/use the medication, e.g., daily, four times per day, every four hours, as needed, etc.
- Section F, "Rationale for Formulary Exception Request", should include information to help explain or clarify the request, as shown in the illustrative examples:
 - The use of formulary drug product(s) is/are contraindicated in the patient.
 - The patient has failed an appropriate trial of formulary or related agents.
 - The choices available in the drug formulary are not suited for the present patient care needs and the drug selected is required for patient safety.
 - The use of a formulary drug product may provoke an underlying medical condition, which would be detrimental to patient care.

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This form is available at the Minnesota Department of Health's website at www.health.state.mn.us/asa and may be made available on websites of group purchasers.

Sections A-F below are to be completed by the Provider. However, please note: Group purchasers making this form available on their websites may pre-populate Section A. Section G is to be completed by the Group Purchaser in response. Additional instructions are on the first page of this form.

A This form is being submitted to:

Group Purchaser Name: _____

Group Purchaser Contact Name (if available): _____

Group Purchaser Address: _____ City, State, ZIP: _____

Group Purchaser Phone: _____ Secure FAX # _____ Other: _____

B Patient Information

Patient Name: _____ DOB: _____
(Last, First, MI) (MM/DD/YYYY)

Patient Address: _____ City, State, ZIP: _____

Health Plan or Pharmacy Plan: _____ Patient Health Plan ID#: _____
(Or Pharmacy Plan ID# if different than Health Plan ID)

C Prescriber Information

Prescriber Name: _____ NPI: _____ Specialty: _____
(Last, First MI)

Prescriber Point of Contact (POC) Name: _____
(If different than Prescriber)

Prescriber/POC Phone: _____ Prescriber/POC Secure Fax#: _____

Clinic/Location/Facility Name: _____

Clinic/Location/Facility Contact Name: _____

Clinic/Location/Facility Address: _____ City, State, ZIP: _____

Clinic/Location/Facility Phone: _____ Secure Clinic/Location/Facility FAX#: _____

D Medication information

Drug Being Requested: _____ Strength: _____
(E.G., 30 MG, 15 MG/ML, ETC)

Dosing Schedule: _____ Duration of Therapy Expected: _____

Is patient currently being treated with the drug requested? Yes No Date Started: _____

Did you specify "Dispense as Written"? If so, explain why below in (E). Yes No

E Clinical Information

Diagnosis Related to Medication Request: _____

Drug Allergies: _____ Height: _____ Weight: _____
(If relevant to the request) (If relevant to the request) (If relevant to the request)

F Rationale for Formulary Exception Request

PREVIOUS THERAPIES TRIED / FAILED

Drug Name	Date Prescribed	Dosing Schedule	Strength	Duration	Describe Adverse Reaction or Efficacy Failure

Comments Regarding Rationale: _____

Any Additional Clinical Information: _____

G Request Determination (to be completed by Group Purchaser) See also the note at the bottom of the box below.

THIS FORMULARY EXCEPTION REQUEST DETERMINATION IS A RESPONSE TO:

Provider Name: _____

Provider Contact Name (if available): _____

Provider Address: _City, State, ZIP: _____

Provider Phone: _____ Secure FAX # _____ Other: _____

Date Formulary Exception Request Received by Group Purchaser: _____ Date of Decision: _____

Group Purchaser Responder/Contact Name: _____ Responder/Contact Information: _____

Approved **Denied** Pharmacy authorization/reference number: _____

Comments Regarding Decision (include effective and end dates of decision if applicable): _____

Additional Information or Instructions

Note: Group purchasers may supply additional instructions or other relevant or legally required information with their response. Examples of additional information might include: Appeals rights and processes; other notifications; other information required for legal or clarification purposes.

CONFIDENTIALITY NOTICE: the information in this form is confidential and intended for the use of the recipient. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance of the contents of this communication is strictly prohibited. If you have received this form in error please immediately notify the sender to arrange for its return. Thank you for your assistance.