



## Mandatory Mail Exception Request

Complete this form to request an exception for a patient to receive a maintenance medication at a network retail pharmacy on a long-term basis.

Patient Information		
Patient Name:		
Date of Birth:		
Plan Participant ID Number:		
Prescriber Information		
Prescriber Name:		
Prescriber Phone Number:		
Prescriber Fax Number:		
<b>The following sections to be completed by the prescriber.</b> <i>(Incomplete or missing information may delay processing and result in the form being returned to the requester.)</i>		
Drug Name:		
Strength:	Dosage Form:	Diagnosis:
1. Is the patient a resident of a nursing home or skilled residence facility? (If so, a signed statement from the nursing home/facility is required.)		
2. If dosing is being titrated, provide clinical rationale for the titration.		
3. If there is a safety concern associated with the availability of a high quantity of medication for the patient, please describe the safety concern.		
4. If the maintenance medication is to treat an acute condition, please describe why the patient requires the requested medication.		
As the prescriber for the brand-name drug above, I certify that the information provided is accurate and complete.		
Prescriber Signature: _____ Date: _____		
<b>Fax the completed form to the Appeals Department at 1-866-689-3092.</b>		

Plan participant privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

©2009 Caremark. All rights reserved.

This document contains confidential and proprietary information of CVS Caremark and cannot be reproduced, distributed or printed without written permission from CVS Caremark.

91-14465c 0826