State of Montana – Dept of Administration
Health care and Benefits Division
Phone: (800)287-8266
Fax: 406-444-0080
P.O. Box 200130
Helena MT 59620-0130

Plan Exception Request

Please fax completed request to 406-444-0080

Provider Information			Patient Information		
Provider Name:			**Please ensure form is filled out in its entirety**		
Specialty:	DEA OR TIN:		Patient Name:		
Office contact:			Patient's ID number:		
Office phone:	Office Fax:		Date of Birth:		
May we fax our response to your office? Yes No			Patient Street Address:		
Office street address:			City	State	Zip
City	State	Zip	Patient's phone number:		

Medication Requested

Name of Drug: Strength: Dosage:

Quantity prescribed per month: Expected duration of therapy:

Clinical Data:

Diagnosis related to use:

***please attach case notes specific to the request**

Reason for Copay Reduction/Tier Exception request: (please check all that apply)

- The patient has a contraindication to preferred brand alternative medications
  Medications that are contraindicated for this patient:

  Please specify the contraindication:

- The patient has failed or been intolerant to prior therapy with preferred tier alternatives medications
  Medications previously used and dates:

- Other: (please specify reason, attach additional sheet if necessary)

Physician Signature (not valid unless signed)____