



MHBP Brand Penalty Exception Request

Complete this form to request an exception for a patient to receive a brand-name drug instead of a generic alternative and pay only the appropriate brand copayment.

Patient Information	Prescriber Information
Patient Name:	Prescriber Name:
Date of Birth:	Prescriber Phone Number:
Plan Member ID Number:	Prescriber Fax Number:

NOTE: The following sections must be completed by the prescriber.

Incomplete or missing information may delay processing and result in the form being returned to the requestor.

Brand Drug Name:	Strength:
Dosage Form:	Diagnosis:

Please answer each of the following questions:

1. List the generic alternative(s) the patient has tried and failed or has been considered for the brand medication listed above.

2. Provide evidence that the generic alternative(s) is unsafe or ineffective or has known interactions with other drugs the patient is currently taking.

3. Additional information pertinent to the patient's condition and request.

As the prescriber for the brand-name drug above, I certify that the information provided is accurate and complete.

Prescriber Signature: _____ **Date:** _____

**Fax the completed form to the Exceptions Department
at 1-888-487-9257.**