Gateway Health
A better way.℠

MEDICAID DRUG EXCEPTION FORM

Please complete and ***fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable*** to Gateway Health℠ Pharmacy Services.
FAX: (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

SECTION A - MEMBER INFORMATION			
First name:	**Last name**:	**Date of Birth:**	**Member ID:**
Allergies:	**Type of reaction(s):**		

SECTION B - PHARMACY INFORMATION	
Pharmacy Name:	**Pharmacy Phone Number:**

SECTION C - CLINICAL INFORMATION			
Drug Name Requested:	**Dosage and Frequency:**	**Quantity:**	**Length of therapy:**
Diagnosis for which drug is being requested:			
Is the Patient currently receiving requested medication? **Yes ☐ No ☐**	**Date Medication Initiated:**		
You must be able to document the therapeutic failure or contraindication to formulary products for a request to be approved.			

FORMULARY ALTERNATIVES THAT HAVE BEEN USED BY THE PATIENT		
Drug Name/ Strength	**Dates Tried:**	**Reason therapy failed or discontinued**
Is member currently or recently hospitalized? **Yes ☐ No ☐**		**Date of Discharge:**
Additional Clinical or Supporting Information: ***Please include office notes, lab data, and other supporting medical literature.***		

SECTION D - PRESCRIBER INFORMATION			
Prescriber Name (printed):		**Prescriber Specialty:**	**NPI Number:**
Office Phone:	**Contact Person:**	**Extension:**	**Office Fax:**
Prescriber Signature:		**Date:**	

If the request is denied, the prescriber can change the prescription to an appropriate formulary alternative or with written member consent file an appeal with Gateway. The Drug Formulary is available on the website at http://www.gatewayhealthplan.com/providers/pharmacy-tools.