

DRUG FORMULARY EXCEPTION REQUEST FORM

This form is to be used by members for the submission of information to request an exception to the St. Louis Graphic Arts Joint Health and Welfare Trust Fund's Maintenance Formulary List. This form must be completed and mailed to the Fund's Claim Office. The request will be reviewed by the Fund's Pharmacy Consultant. The decision will be communicated back to the person submitting the form.

Member's Name: _____ Social Security

No.: _____

Member's Address: _____ Telephone No.:

_____ City: _____ State: _____ Zip

Code: _____ Patient's Name: _____ Patient's Birth

Date: _____ Prescribing Physician: _____

Telephone No.: _____

Drug Name: _____ Drug Strength:

Date Patient Started Medication _____ Quantity of Each

Filling: _____ Anticipated Duration of this Medication

Therapy: _____

Patient Condition Indicating the use of this Medication:

Frequency of Physician Visits for this Condition:

The medication stated above is for the treatment of the patient indicated above for the condition noted.

Physician Signature: _____ Date: _____

I certify that the information provided on this form is correct to the best of my knowledge and that the medication prescribed for this patient will be for the personal use of this patient and will not be given or consumed by any other person.

Member's Signature: _____ Date: _____