COPAY 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 brand copay penalty. This form must be completed and mailed to the Fund Office. The request will be reviewed by the Fund's Pharmacy Consultant.

Member's Name: _____Social Security No.: _____

Member's Address: _____City:_____

State:_____ Zip Code:_____ Telephone No.:_____

Patient's Name: _____ Patient's Birth Date:_____

Prescribing Physician:_____ Telephone No.:_____

Drug Brand Name: _____ Drug strength:_____

Drug Generic Name: _____

Date Patient Started Medication:_____ Quantity of Each Filling:_____

Anticipated Duration of this Medication Therapy:_____

Date Patient Filled the Generic Form of this Medication: _____

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. The patient has tried the Generic Form of this medication and failed to obtain the desired results. The brand name medication noted above is required for the proper treatment of this patient.

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:_____