



**Medicare Advantage- Prescription Drug Plan  
Non-Formulary Drug Request Form**  
Incomplete Forms May Delay Processing

PHYSICIAN NAME		PATIENT NAME	
OFFICE CONTACT PERSON		PATIENT ID #	
PHYSICIAN PHONE	PHYSICIAN FAX	PATIENT DATE OF BIRTH	
PHYSICIAN ADDRESS			
Street		City	State Zip

Name of Medication requested: \_\_\_\_\_

Dosage Form of Medication Requested: \_\_\_\_\_  
(injectable, pill/capsule/tablet, suppository, liquid, etc.)

Formulary Alternatives tried and failed: \_\_\_\_\_  
Reason for Failure: \_\_\_\_\_

Additional clinical justification for alternative medication requested: (Please be specific) \_\_\_\_\_  
\_\_\_\_\_

**Please complete the following if applicable:**  
Certain drugs may be covered under Medicare PART D or PART B. (please see the DMERC website <http://palmettogba.com> for PART B coverage clarification) If drug is covered under PART D, please give reasons below.  
\_\_\_\_\_  
\_\_\_\_\_

I certify that, to the best of my knowledge the above information is accurate.

Physician Signature: \_\_\_\_\_

**Please Return Completed Form To:**  
Fax number: 1-888-446-8535  
Address: PARTNERS  
Attention: Exceptions-Health Services  
P.O. Box 17509  
Winston-Salem, NC 27116-7509  
Provider telephone: 1-888-296-9790