

**Exception Request Form¹
Horizon Pharmacy Department**

All areas must be completed to allow for review of this request
Please FAX completed form to 973-274-2285
For questions, please call 1-877-542-0091, from 9:00 AM to 5:00 PM EDT Monday through Friday

Date: _____

Patient Information:

Name: _____

DOB: _____

ID #: _____

Gender: _____

Requested Medical Information:

Drug Name and Strength: _____

Quantity: _____

Expected Duration of Therapy: _____

Patient's Diagnosis: _____

Has the patient previously received this medication? Yes No

If yes, how long has the patient been treated with this medication? _____

This medication has a quantity limit or dispensing edit for age or gender. Please provide clinical information to support prescribing this medication in quantities in excess of the recommended allowances or outside of the parameters for age and gender. (Attach chart notes or letter documenting outcomes from using the prescribed drug within the dispensing limit, and other therapeutic alternatives previously used).

Prescriber Information:

Prescriber's Name: _____

Telephone Number: _____

Address: _____

Fax Number: _____

DEA #: _____

Nurse or Contact Name: _____

Prescriber's Signature: _____

Date: _____

FOR OFFICE USE ONLY:

Approved / Duration

Denied

Additional Comments:

¹ Use this form to request quantities in excess of the Dispensing Limit and for requests outside the parameters for age/gender