

PHARMACY EXCEPTION TO RULE (ETR) REQUEST FORM
Fax this completed form to Coordinated Care of Washington, Inc. Pharmacy Department at (866) 270-0122. For questions, call 1-877-644-4613 ext. 69622

I. PROVIDER INFORMATION		II. MEMBER INFORMATION			
Prescriber name (print):		Member name:			
Office contact name:		Identification number:			
Group name:		Group number:			
Fax:		Date of Birth:			
Phone:		Medication allergies:			
III. DRUG INFORMATION (One drug re	quest per form)				
Drug name:			Strength:		
Direction for use:			Quantity:		
Diagnosis relevant to this request:			ICD-10 Diagnosis code:		
Expected length of therapy:					
Medication History for this Diagnosis:					
A. Is member currently treated on this medication? ☐ Yes; How Long? [go to item B] ☐ No [skip items B & C; go to item D]					
B. Is this request for continuation of a previous approval? ☐ Yes [go to item C] ☐ No [skip item C; go to item D]					
C. Has strength, dosage, or quantity required per day increased or decreased? ☐ Yes [go to item D] ☐ No [skip item D; indicate rationale for continuation in Section IV and submit form					
D . Please indicate previous treatment and outcomes below.					
Drug Name (include strength and dosage)	Dates of Therapy	py Reason for Discontinuation			
1					
2					
3					
4					
5					
IV. RATIONALE FOR ETR REQUEST / P.	ERTINENT CLINIC	CAL INFORMATION (Required)		
1. Is this an Exception to Rule (ETR) red	quest?	□ No			
2. What is the original denied case number and date of denial? EPA Denial Date:					
3. Does the requested medication being prescribed fall within accepted standards and precepts of good medical practice? Yes No If yes, list/provide supporting literature:					
4. Does the prescriber attest that this tr	reatment represen	ts cost-effective use of	public funds? Yes No		

5.	Is the member's clinical condition so different from the majority that these is no equally effective, less costly				
	covered service or equipment that meets the patient's needs? Yes No				
	If yes, must attach documentation				
6.	Does the prescriber certify that medical treatment or items of service which are co				
	Washington Apple Health program and which, under accepted standards of medical				
	appropriate for the treatment of the illness or condition, have been found to be one	e of the following? (Check			
	which applies)				
	 Medically ineffective in the treatment of this member's condition; or Inappropriate for this specific member 				
7.	Additional information and explanation of why preferred/covered medications list	tod on Coordinated Care's			
/.	Preferred Drug List would not meet the patient's needs. Please prefer to <u>www.coo</u>				
	a list of preferred alternatives.	I dinateucai eneaitii.com Ioi			
	a list of preferred afternatives.				
Prov	ider Signature:	Date:			