

**Colorado Department of Health Care Policy and Financing**

**EXCEPTION TO PHARMACY COVERAGE REQUEST FORM**

Requesting provider contact information:

Name:

Address:

Phone:

Fax:

Colorado Medicaid Provider ID#:

1. Client information (name of adults and/or children):

NAME: Last, First MI	BIRTH DATE	CLIENT MEDICAID ID / ELIGIBILITY TYPE

2. MEDICAID RULE (identify rule, standard, policy, or documentation describing current coverage):

3. Specific nature of request including HCPCS code and/or specific NDC for coverage (overrides are specific to NDC requested and NDC is required)

4. Justification for request conforming with 10 CCR 2505-10 section 8.016.3 et seq.  
Attach additional information as needed, including documentation of FDA-approved IND for Stiripentol or Clobazam requests:

5. Alternative treatment(s) explored:

6. Probable course of treatment if coverage is denied:

7. Previous coverage of this treatment for patient:

Any known previous requests for coverage of this treatment?  YES  NO Date: \_\_\_\_\_

What was previously requested?

Disposition:  APPROVED  DENIED

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8. Dates for which this exceptional coverage is being requested:

ONE-TIME: Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

CONTINUING: Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

9. Additional cost of exceptional coverage:

For medical exception requests, specify the estimated total cost of exceptional coverage.

MONTHLY AMOUNT \$ \_\_\_\_\_ or  ONE-TIME AMOUNT \$ \_\_\_\_\_ or  TOTAL AMOUNT \$ \_\_\_\_\_

**10. TO BE COMPLETED BY CHIEF MEDICAL OFFICER OR DESIGNEE**

APPROVED  DENIED Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Comments on determination:

**11. STATE OFFICE ACTION**

Decision communicated to Requestor and Benefits Management Section: Date \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(staff reporting decision to provider)

**Pursuant to 10 CCR 2505-10, sections 8.050 and 8.016.4.A, determinations of exceptional coverage are subject to appeal. A denied request for exceptional coverage is an adverse action. The information in Section 11 above is the reason for the determination.**