BRAND PENALTY EXCEPTION REQUEST

Complete this form to allow the patient to receive a brand-name drug instead of a generic alternative and pay only the appropriate brand copayment*.

Patient Information	**Prescriber Information**
Patient Name:	Prescriber Name:
Date of Birth:	Prescriber Phone Number:
Plan Participant ID Number:	Prescriber Fax Number:

NOTE: The following sections must be completed by the prescriber.

Incomplete or missing information may delay processing and result in the form being returned to the requestor.

Brand Drug Name:	Strength:
Dosage Form:	Diagnosis:

Please answer each of the following questions:

1. What generic alternative(s) has the patient tried or has been considered?

2. Provide evidence that the generic alternative(s) is unsafe or ineffective or has known interactions with other drugs the patient is currently taking.

3. Additional information pertinent to the patient's condition and request:

As the prescriber for the brand-name drug above, I certify that the information provided is accurate and complete.

Prescriber Signature: _____ **Date:** _____

Fax completed form to the CVS Caremark Appeals Department toll-free at 1-866-689-3092.

*Copayment, copay or coinsurance means the amount a plan participant is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.