Return completed form to:
PSC-CUNY Welfare Fund
P.O. Box 280278
Brooklyn, NY 11228 Office: 212-354-5230
www.psccunywf.org

PRESCRIPTION DRUG EXEMPTION REQUEST FORM

Employee/Patient Information: Please Print Clearly			
Patient Name (Last, First)	Relationship to Member	Sex ☐M ☐F ☐U	Date of Birth / /
Patient Email	**CVS Patient Member ID**	Patient Contact # ( )	
Member Name (Last, First)			
Authorization to Release Information: *I hereby authorize any physician, insurance company, CVS/Caremark, prepayment organization, employer, hospital, or dentist, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this plan. I certify that the information provided by me in support of this claim is true and correct.* ***Exemption Request Form cannot be processed unless authorization is signed.*** Member Signature: _____ Date: _____			

To be completed by the Physician for Evaluation by the PSC-CUNY Welfare Fund Pharmaceutical Consultant Please include as **Clinical Documentation**, for a timely review.		
Exemption Type: ☐ **Brand-Name Drug** _____ ☐ **Non-Formulary Drug** ☐ **Exceed Drug Quantity Limit**		
Physician Name	Address:	Contact # ( )
What is the medical reason for the request? Attach any medical literature to support your request.		
If a Brand-name medication is requested when a Generic is available, has the patient used the Generic? If so, specify timeframe and results.		
What other alternative treatments has the patient tried for this condition, if any?		
Physician's Signature: _____ Date: _____		

FOR PSC-CUNY WELFARE FUND USE ONLY	
Date Request Received:	Date Sent to Consultant:
☐ APPROVED	☐ DENIED
Comments:	
Consultant's Signature: _____ Date: _____	