



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

PRESCRIPTION DRUG EXEMPTION REQUEST FORM

Employee/Patient Information: Please Print Clearly			
Patient Name (Last, First)	Relationship to Member	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /
Patient Email	CVS Patient Member ID	Patient Contact # ()	
Member Name (Last, First)			
<p>Authorization to Release Information: <i>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.</i></p> <p>Exemption Request Form cannot be processed unless authorization is signed.</p>			
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: <input type="checkbox"/> Brand-Name Drug _____ <input type="checkbox"/> Non-Formulary Drug <input type="checkbox"/> 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:
<input type="checkbox"/> APPROVED	<input type="checkbox"/> DENIED
Comments:	
Consultant's Signature: _____ Date: _____	