Return completed form to:
PSC-CUNY Welfare Fund
61 Broadway, 15th Floor
New York, NY 10006
Office: 212-354-5230 Fax: 212-354-5363

PRESCRIPTION DRUG EXEMPTION REQUEST FORM

Employee/Patient Information: Please Print Clearly			
Patient Name (Last, First)	Relationship to Member	Sex ☐M ☐F	Date of Birth / /
Member Name (Last, First)	CVS Member ID	Contact # ( )	
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 much detail as possible, in order for 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 mediation is requested when a Generic is available, has the patient used the Generic before? 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: _____	