Exclusion Override Form - Specialty Prescription Drugs

MSD of North Posey County Employee Benefit Plan

Covered Person Name ("Covered Person"):	
Address:	
Covered Person DOB	
Drug Name	
Approximate Plan Cost	

Procedure Certification

Procedural Requirement	Date Completed
Covered Person joined as a member of Patient Advocacy Program:	
Covered Person fully followed and completed the Patient Advocacy Program procedure to apply for and submit information to obtain any support or aid with respect to the Specialty Prescription Drug that is excluded – date completed:	
All aid submissions to any form of Prescription Drug support, including any available manufacturers coupons, financial aid, grants, or governments programs exhausted and all rejected:	
Evidence of Medical Necessity obtained (PA completed by PBM):	
This Form Completed and Submitted to the Plan:	

I, the representative of the plan sponsor listed above, hereby state and affirm that I am requesting a Specialty Prescription Drug Exclusion Override based upon the Specialty Prescription Drug Exclusion Override amendment. Please allow the medication to process for this member according to the True Rx Assist plan parameters. This approval will remain in unless removed by request from a representative of the plan sponsor.

Dated: January 8, 2021

Michael Galvin
Plan Sponsor Representative

Michael Galvin
Print Name

All other provisions of this document remain as stated. The above is effective on and after the dates stated herein.

Signed this _____day of _____, 2021.

Michael Galvin, Superintendent
Authorized Representative MSD of North Posey County Employee Benefit Plan and Title