

Drug Exclusion Form

This Drug Exclusion Form is to be used by the Clinical Center of Excellence (CCE) to request restrictions on inappropriate medications for patients.

This form must be faxed to the WTCHP Secure Fax Line at **877-646-5308** (no other transmission will be accepted).

REQUIRED MEMBER INFORMATION:

Date of this Request (mm/dd/yyyy): _____

Member Name: _____

Member Date of Birth (mm/dd/yyyy): _____

Member ID (911# only): _____

Prescription Number of Inappropriate Medication, found in your CCE's Weekly Cancer Treatment Utilization Report: _____

Medication	NDC Number	Restrict Entire Therapeutic Class (Y/N)?
Restriction Justification: 		

REQUIRED CCE INFORMATION:

Member CCE: _____

Name of CCE Point of Contact Regarding this Form: _____

CCE Point of Contact Telephone Number: _____

Note: Please direct any questions on this process to WTC_HP_Care@csc.com. Do not send personally identifiable information (PII) or protected health information (PHI) to the WTC_HP_Care@csc.com email address. Completed forms will only be accepted via the WTCHP Secure Fax Line, as described above.