

**EMPLOYEE PHARMACY**

BRYN MAWR HOSPITAL  
130 SOUTH BRYN MAWR AVENUE  
BRYN MAWR, PA 19010  
610-526-3600

**MEDICAL EXCEPTION FORM – GENERIC COST-PLUS PROGRAM**

You and your doctor should complete this form to submit a request for an exception for the co-payment you are required to pay to the MLH Employee Pharmacy. Once the form is completed, please return it to the MLH Employee Pharmacy.

**PERSONAL INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Work Phone: \_\_\_\_\_

MLH Work Location: \_\_\_\_\_

Brand Name Drug Requested: \_\_\_\_\_

**EMPLOYEE STATEMENT**

Please describe the reason(s) you are requesting an exception to the normally required Employee Pharmacy co-payment under the Generic Cost-Plus Program.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PHYSICIAN STATEMENT**

Please describe the **medical or clinical reason(s)** why this patient is required to use the brand name form of this drug. Describe specifically any adverse reaction or side effects your patient has experienced in the use of the generic form of the drug requested.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician Signature: \_\_\_\_\_ Print: \_\_\_\_\_

Physician Office Phone Number: \_\_\_\_\_