



REQUEST FOR DRUG COVERAGE
FAX COMPLETED FORM TO: (888) 447-4369

Failure to complete this form in its entirety may result in an adverse coverage determination due to lack of information.

SECTION A – MEMBER INFORMATION

First Name:	Last Name:	Date of Birth:	Member ID:
Allergies:	Type of Reaction(s):		

SECTION B – DRUG INFORMATION

Drug Name:	Dose & Frequency:	Quantity:	Length of Therapy:
Associated Diagnosis:	<input type="checkbox"/> New Prescription <input type="checkbox"/> Existing Therapy	Date Initiated:	Was medication initiated in hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION C – TYPE OF REQUEST

- ☐ Request for prior authorization for the prescribed drug.
☐ Request for step therapy for the prescribed drug.
☐ Request for an exception to existing criteria (prior authorization or step therapy exception).
☐ Request for a drug that is not on the list of covered drugs (formulary exception).
☐ Request for an exception to the limit on the number of doses (quantity limit exception).
☐ Request for a lower copayment (tiering exception).
☐ Other (please specify): _____
☐ **Request for Expedited Review:** By checking this box and signing below, I certify that applying the 72-hour review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

SECTION D – SUPPORTING STATEMENT

When requesting an exception, the prescribing physician **must** provide a supporting statement indicating why the requested prescription drug is medically necessary and formulary alternatives OR the number of doses available under a dose restriction have been or are likely to be ineffective, adversely affect patient compliance, or cause an adverse reaction. **Please provide the supporting statement below and attach any additional supporting information (i.e. chart documentation).**

SECTION E – FORMULARY ALTERNATIVES TRIED

Drug Name/Strength:	Dates Tried:	Reason therapy failed, discontinued, or contraindicated:

SECTION F – PRESCRIBER INFORMATION

Prescriber Name (printed):	Specialty:	NPI Number:
Office Phone:	Office Fax:	
Prescriber Signature:	Date:	

MAY PHOTOCOPY FOR OFFICE USE

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

If you need to speak to a Pharmacy Services Representative, call 1-800-685-5209 (PA), 1-888-447-4505 (OH), or 1-855-847-6430 (NC).

Formulary information can be found at www.medicareassured.com.