Non-Formulary Prescription Request

Override(s)	Approval Duration
Prior Authorization	1 year

Medications	Quantity Limit
Non-Formulary Prescription Requests	May be subject to quantity limit

APPROVAL CRITERIA

I. In order to receive a non-formulary medication, the individual must meet one of the following criteria:

A. Individual has previously tried and failed 2 (two) formulary products (when available): One of which has to be in the same specific drug class; the other product can be in a different drug class however it must have the same indication as the product requested; **OR**
B. For combination products: individual has previously tried and failed 2 (two) formulary products (when available): One of which must be in the same specific class as at least one ingredient in non-formulary combination product; **OR**
C. For Non-Formulary antibiotics/ anti-virals/ anti-fungals, individual has previously tried and failed one formulary antibiotic/ anti-viral/ anti-fungal product within the same route of administration; **OR**
D. The individual has a documented drug interaction with a formulary drug; **OR**
E. The individual has documented adverse drug experiences (side effects, adverse drug reaction) with a formulary drug.

II. Any request for a Non-Formulary medication that does not meet the criteria in section I shall be subject to medical necessity review.

Key References:

1. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2020. URL: http://www.clinicalpharmacology.com. Updated periodically.
2. DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm.
3. DrugPoints® System [electronic version]. Truven Health Analytics, Greenwood Village, CO. Updated periodically.
4. Lexi-Comp ONLINE™ with AHFS™, Hudson, Ohio: Lexi-Comp, Inc.; 2020; Updated periodically.

Federal and state laws or requirements, contract language, and Plan utilization management programs or polices may take precedence over the application of this clinical criteria.

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IngenioRx, Inc.

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

Contains Confidential Patient Information

Complete form and fax back accordingly:

State:
Connecticut - 844-474-3350**| Georgia -** 844-512-9002**|**
|Indiana - 844-521-6940**| Kentucky -** 844-521-6947**| Maine -** 844-474-3351**| Missouri -** 844-534-9053**|**
|Nevada - 844-534-9054**| New York -** 844-474-3356**| Ohio -** 844-534-9055**|**
|Wisconsin - 844-534-9056**| Virginia -** 844-474-3358**|**

Exchange:
Connecticut - 844-474-6220**| Georgia -** 844-512-9003**|**
|Indiana - 844-471-7938**| Kentucky -** 844-471-7939**| Maine -** 844-474-6221**| Missouri -** 844-471-7940**|**
|Nevada - 844-471-7941**| New York -** 844-474-6226**| Ohio -** 844-471-7942**|**
|Wisconsin - 844-474-3340**| Virginia -** 844-474-6227**|**

Plan Specific:
COVA - 844-474-6218

Patient Name:	Member ID#:

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

Patient Information: This must be filled out completely to ensure HIPAA compliance			
First Name:	Last Name:	MI:	Phone Number:
Address:	City:	State:	Zip Code:
Date of Birth:	☐Male ☐Female	Height (in/cm): ______Weight (lb/kg):_______	Allergies:
Patient's Authorized Representative (if applicable):	Authorized Representative Phone Number:		
Insurance Information			
Primary Insurance Name:	Patient ID Number:		
Secondary Insurance Name:	Patient ID Number:		

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Prescriber Information

First Name:	Last Name:	Specialty:

Address:	City:	State:	Zip Code:

Requestor (if different than prescriber):	Office Contact Person:
NPI Number (individual):	Phone Number:
DEA Number (if required):	Fax Number (in HIPAA compliant area):
Email Address:	

Medication / Medical and Dispensing Information

Medication Name (list all that apply):

☐New Therapy ☐Renewal

If Renewal: Date Therapy Initiated: Duration of Therapy (specific dates):

☐Copay review (provide details): ___

☐Maine: Proactive Non-formulary request (provide start date):___

How did the patient receive the medication?

☐Paid under Insurance

Insurance Name:___ Prior Auth Number (if known): ___

☐Other (explain):

Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:

Administration:

☐ Oral/SL ☐ Topical ☐ Injection ☐ IV ☐ Other:___

Administration Location:

☐ Patient's Home ☐ Ambulatory Infusion Center

☐ Physician's Office ☐ Long Term Care

☐ Home Care Agency ☐ Outpatient Hospital Care

☐ Other (explain): ___

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Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization request.

1. Has the patient tried any other medications for this condition? YES (if yes, complete below) NO		
Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

2. List Diagnoses:	ICD-9/ICD-10:

3. Required clinical information - Please provide all relevant clinical information to support a prior authorization review.

Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the preferred drug. Please provide any additional clinical information or comments pertinent to this request for coverage or required under state and federal laws.

Attachments

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:____**Date:**___________________________

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