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

The individual must meet the following criteria to receive a non-formulary product if formulary alternative(s) are available:

I. If the requested product is a brand or generic product without an FDA approved generic therapeutic equivalent or interchangeable biosimilar available on formulary:
   A. Individual has had a trial and inadequate response or intolerance to at least two formulary alternative products FDA approved for the same condition and within the same therapeutic class; **AND**
      1. Confirmation has been provided describing the nature of the inadequate response or intolerance for each product;
         OR
      2. Confirmation has been provided that a completed FDA MedWatch Adverse Event Reporting Form has been submitted to the FDA for each product;

   OR

   B. If the request is for a combination product for which the individual components are available as generic and/or preferred formulary products at similar doses, then the individual has had a trial and inadequate response or intolerance to the individual components that is likely due to an inactive ingredient; **OR**
   C. If the request is for a product with an available alternative dosage form for the same active ingredient on formulary, then confirmation has been provided indicating the clinical reason why the individual is unable to take an alternative formulary dosage form; **OR**
   D. If only one formulary product is available in the same therapeutic class, the individual has had a trial of and inadequate response or intolerance to the one formulary product for the same condition and within the same therapeutic class.

II. If the requested product is a brand medication with an FDA approved generic therapeutic equivalent or interchangeable biosimilar available on formulary:
   A. Individual has had a trial and inadequate response or intolerance to the generic therapeutic equivalent or interchangeable biosimilar that is likely due to an inactive ingredient, and the inadequate response or intolerance is not anticipated with the requested product; **AND**
      1. Confirmation has been provided describing the nature of the inadequate response or intolerance to the generic therapeutic equivalent or interchangeable biosimilar;

OR

2. Confirmation has been provided that a completed FDA MedWatch Adverse Event Reporting Form has been submitted to the FDA;

AND

B. **ONE** of the following**:**

1. Individual has had a trial and inadequate response or intolerance to at least two formulary alternative products FDA approved for the same condition and within the same therapeutic class; **AND**
    a. Confirmation has been provided describing the nature of the inadequate response or intolerance for each product;
    OR
    b. Confirmation has been provided that a completed FDA MedWatch Adverse Event Reporting Form has been submitted to the FDA for each product;

OR

2. If the request is for a combination product for which individual components are available as generic and/or preferred formulary products at similar doses, then the individual has had a trial and inadequate response or intolerance to the individual components that is likely due to an inactive ingredient; **OR**
3. If the request is for a product with an available alternative dosage form for the same active ingredient on formulary, then the individual is unable to take an alternative formulary dosage form; **OR**
4. If only one formulary product is available, the individual has had a trial of and inadequate response or intolerance to one formulary product for the same condition and within the same therapeutic class.

III. Any Non-Formulary medication without formulary or dosage form alternatives may be approved based on FDA approved labeled indications or accepted compendia off-label indications (e.g. AHFS, Micromedex, NCCN, etc.).

NOTE:

If the requested product is being prescribed for an indication that is an excluded benefit by the applicable health plan (e.g., weight loss, erectile dysfunction, fertility, cosmetic, hair loss, medical foods), the non-formulary exception process will not apply.

Key References:

1. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.: 2022. 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.; 2022; Updated periodically.

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**| New Hampshire - 844-474-3355|**

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**| New Hampshire - 844-474-6224|**

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:			

PRESCRIPTION DRUG PRIOR AUTHORIZATION REQUEST FORM

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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.

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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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.

1. Has the patient tried any other medications forthis 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:**_____