



REQUEST FOR DRUG COVERAGE

Have your provider submit electronically at www.CoverMyMeds.com or Fax completed form to: 1-855-476-4158

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

MEMBER INFORMATION
Table with 4 columns: First Name, Last Name, Date of Birth, Member ID; Weight, Height, Drug Allergies, Type of Reaction(s)

DRUG INFORMATION
Section with checkboxes for ONCOLOGY USE, Drug Name, Strength & Route, Frequency, Quantity, Date Initiated, Was medication initiated in hospital?, Expected Length of Therapy, Diagnosis, ICD Code

BILLING INFORMATION
This medication will be billed: At a pharmacy OR Medically, JCODE:
Place of Service: Hospital, Provider's office, Member's home, Other
Facility NPI:

TYPE OF REQUEST
List of request types: Request for prior authorization, Request for an exception to existing criteria, Request for a drug that is not on the list of covered drugs, Request for an exception to the limit on the number of doses, Request for a lower copayment, 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

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).

FORMULARY ALTERNATIVES TRIED
Table with 3 columns: Drug Name/Strength, Dates Tried, Reason for discontinuation

PRESCRIBER INFORMATION
Prescriber Name (printed), Specialty, NPI Number, Prescriber Address, 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 1-855-401-8251. Formulary information can be found at highmarkhealthoptions.com/Duals

Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association. Highmark Health Options Duals is offered by Highmark Blue Cross Blue Shield. Highmark Health Options Duals offers HMO plans with a Medicare Contract. Enrollment in these plans depends on contract renewal.