

## REQUEST FOR DRUG COVERAGE

Have your provider submit electronically at <a href="www.CoverMyMeds.com">www.CoverMyMeds.com</a> 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			
First Name:	Last Name:	Date of Birth:	Member ID:
Weight:	Height:	Drug Allergies:	Type of Reaction(s):
	DRUG IN	FORMATION	
FOR ONCOLOGY USE			
Drug Name:	Strength & Route:	Frequency:	Quantity:
New Prescription Existing Therapy	Date Initiated:	Was medication initiated in hospital? Yes No	Expected Length of Therapy:
		ICD Code:	
	BILLING	NFORMATION	
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  Request for prior authorization or 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):			
			g 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 <b>must</b> 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. <b>Please provide the supporting statement below</b>			
and attach any additional supporting information (i.e. chart documentation).			
FORMULARY ALTERNATIVES TRIED  Drug Name/Strength: Dates Tried: Reason for discontinuation:			
Drug Name/Strength:	Dates Trie	Reason for dis	scontinuation:
PRESCRIBER INFORMATION			
Prescriber Name (printed):		Specialty:	NPI Number:
1			
Prescriber Address:			
Prescriber Address:  Office Phone:		Office Fax:	

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 <a href="https://hipharkhealthoptions.com/Duals">highmarkhealthoptions.com/Duals</a>

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