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

DRUG INFORMATION			
☐ **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:
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

☐ 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):

☐ **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		
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

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