

## 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.

	MEMBE	R 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 hospital? Yes No	1 0 1;	
Diagnosis:		ICD Code:		
	BILLING	GINFORMATION		
This medication will be billed: [	At a pharmacy <b>OR</b> Med	ically, JCODE:		
Place of Service: Hospital	Provider's office Member	's home Other		
Facility NPI:				
		OF REQUEST		
	tion or step therapy for the prese			
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):	lent (dering exception)			
	eview: By checking this box and	signing below. I certify that an	plying the 72 hour review timeframe may	
	health of the enrollee or the enro			
, ,		ING STATEMENT		
			t indicating why the requested prescription	
			r a dose restriction have been or are likely	
			wide the supporting statement below	
and attach any additional su	pporting information (i.e. cha	rt documentation).		
	FORMILLARY	ALTERNATIVES TRIED		
Drug Name/Strength:	Dates T		For discontinuation:	
	PRESCRIB	ER INFORMATION		
Prescriber Name (printed):		Specialty:	NPI Number:	
Prescriber Address:				
Office Phone:		Office Fa	Office Fax:	
Prescriber Signature:		Date:	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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