

Fax completed form to: 1-866-868-0858

Questions, please call: 1-866-316-6049



SELECTCARE of TEXAS, L.L.C.

## Important Information About Prescription Drug Coverage

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Request for Coverage of a Non-Formulary Drug: Please respond.

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- Please complete the attached Request for Coverage of a Non-Formulary Drug Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

**Please note:** By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

### Information about this Request for Coverage of a Non-Formulary Drug

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Use this form to request coverage of a drug that is not on the formulary. To process this request, documentation that all formulary alternatives would not be as effective or would have adverse effects is required. Please provide clinical information or other evidence supporting the medical necessity of the non-formulary drug, including previous formulary drugs attempted for this patient's condition. If the formulary exception is approved, it will be reimbursed at a Tier 3 copay for the calendar year.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

Last Updated: 12/06/2007

M0018\_FMLRYEXC\_1107 CMS 11/28/07 H4506

# Request for Coverage of a Non-Formulary Drug

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## Patient Information

Name \_\_\_\_\_  
Member ID \_\_\_\_\_  
Medicare ID \_\_\_\_\_  
Date of birth \_\_\_\_\_ Sex: M / F  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_  
Nursing home resident? YES / NO  
Home care patient? YES / NO

## Prescriber and Pharmacy Information

Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Pharmacy name \_\_\_\_\_  
NCPDP \_\_\_\_\_  
NPI \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

### All items below this line are for Physician Use Only

#### Information for Requested Drug

Drug Name: \_\_\_\_\_

Strength: \_\_\_\_\_ Dosage form: \_\_\_\_\_ Qty per 30 days: \_\_\_\_\_ Drug is (circle one): Newly prescribed/Refill

Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

#### Request for Coverage of a Non-Formulary Drug Criteria

- Please provide medical justification for non-formulary drug exception.
  - All of the covered drugs on any tier of the formulary for treatment of the same condition (check applicable statements and provide justification):
    - All formulary agents would not be effective
    - All formulary agents would have adverse effects
    - Patient preference for nonformulary drug (formulary agent may be effective)

**Medical Justification:** Provide clinical information or other evidence to support medical necessity for this request. List previous drugs and doses attempted for this patient, condition and dates or approximate dates or duration of treatment (if known). Document adverse effects requiring discontinuation and/or reason for perceived ineffectiveness. Attach additional pages if necessary. \_\_\_\_\_

DRUG NAME & DOSE	REASON FOR D/C	DURATION OF THERAPY

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_