



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			
<input type="checkbox"/> FOR ONCOLOGY USE			
Drug Name:	Strength & Route:	Frequency:	Quantity:
<input type="checkbox"/> New Prescription <input type="checkbox"/> Existing Therapy	Date Initiated:	Was medication initiated in hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No	Expected Length of Therapy:
Diagnosis:		ICD Code:	
BILLING INFORMATION			
This medication will be billed: <input type="checkbox"/> At a pharmacy OR <input type="checkbox"/> Medically, JCODE: _____			
Place of Service: <input type="checkbox"/> Hospital <input type="checkbox"/> Provider's office <input type="checkbox"/> Member's home <input type="checkbox"/> Other			
Facility NPI: _____			
TYPE OF REQUEST			
<input type="checkbox"/> Request for prior authorization or step therapy for the prescribed drug <input type="checkbox"/> Request for an exception to existing criteria (prior authorization or step therapy exception) <input type="checkbox"/> Request for a drug that is not on the list of covered drugs (formulary exception) <input type="checkbox"/> Request for an exception to the limit on the number of doses (quantity limit exception) <input type="checkbox"/> Request for a lower copayment (tiering exception) <input type="checkbox"/> Other (please specify): _____			
<input type="checkbox"/> 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 (e.g., 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