

PRESCRIPTION DRUG MEDICATION REQUEST FORM FAX TO 1-866-240-8123



<http://highmark.formularies.com>

To view our formularies on-line, please visit our Web site at the addresses listed above.

Fax each form separately. Please use a separate form for each drug.

Print, type or write legibly in blue or black ink. *See reverse side for additional details*

PATIENT INFORMATION			
Subscriber ID Number	Highmark Coverage <input type="checkbox"/> MA-PD <input type="checkbox"/> PDP	Group Number	
Patient Name	Patient Telephone Number	Date of Birth	
Patient Address	City	State	Zip Code
CLINICAL / MEDICATION INFORMATION			
Drug Name	Strength or Dose	Requested Quantity per Month	
Diagnosis		Name of the Carrier who paid for Most Recent Transplant	
Type of Transplant <input type="checkbox"/> Lung <input type="checkbox"/> Heart <input type="checkbox"/> Kidney <input type="checkbox"/> GVH <input type="checkbox"/> Other _____	Date of Most Recent Transplant	Most Recent Transplant Payer (check one) <input type="checkbox"/> Commercial <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Medicare FFS	
Alternatives Tried / Used By Patient (if applicable)			
Drug Name	Strength	Documentation of Failure of Therapy	
Drug Name	Strength	Documentation of Failure of Therapy	
Drug Name	Strength	Documentation of Failure of Therapy	
Medical Rationale / Reason for Drug Therapy / Treatment Plan			
PHYSICIAN INFORMATION (needed for mailing notification - please print legibly)			
Physician Name	NPI or Tax ID # (Required)	Phone	Fax
Physician Address	City	State	Zip Code
Suite / Building	Physician Signature		Date
MEDICARE	COMMERCIAL	REQUEST TYPE	
<input type="checkbox"/> Tiering Exception	<input type="checkbox"/> Non-Formulary	<input type="checkbox"/> Standard Request	<input type="checkbox"/> Peer to Peer
<input type="checkbox"/> Non-Formulary	<input type="checkbox"/> Prior Authorization	<input type="checkbox"/> Expedited Request	<input type="checkbox"/> Expedited Appeal
<input type="checkbox"/> Prior Authorization			<input type="checkbox"/> Standard Appeal

Once a clinical decision has been made, a decision letter will be mailed to the patient and physician.

For other helpful information, please visit the Highmark Web site at:

www.highmark.com

INSTRUCTIONS FOR COMPLETING THE FORM

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.
NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
3. Please provide the physician address as it is required for physician notification.
4. Fax the **completed** form to **1-866-240-8123**

CLINICAL MANAGEMENT PROCEDURES

In general, when requesting coverage for a medication, the following information in the bullet points below is required:

NON-FORMULARY

- Most products: documentation of a trial of at least two formulary products

PRIOR AUTHORIZATION

Below is a list of common drugs and/or therapeutic categories that require prior authorization:

- Agents used for fibromyalgia (e.g. Cymbalta, Lyrica, Savella)
- Testosterone therapies
- Miscellaneous Items: contraceptives, Provigil, immediate release fentanyl products
- Specialty drugs (e.g. Enbrel, Sutent, Tracleer, etc.)

MANAGED PRESCRIPTION DRUG COVERAGE (MRXC)

The MRXC program includes coverage for specific drug therapy categories with set thresholds or limits. The MRXC program uses specific criteria as set forth by Pharmacy and Therapeutics Committee to assess the information provided to support requests for additional quantities.

Below is a list of common drugs and/or therapeutic categories that are managed under our MRXC program:

- Medications used to treat Migraines (e.g. Amerge, Imitrex, Maxalt, etc.)
- Medications used to treat Onychomycosis (Lamisil and Sporanox)
- Leukotriene Modifiers (Singulair, Accolate, and Zflo)
- Pain Management (OxyContin, Opana ER, etc.)

Please note that the drugs and therapeutic categories managed under our Prior Authorization and MRXC programs are subject to change based on the FDA approval of new drugs.