HEALTH CHOICE
GENERATIONS

Fax completed form to: 1-855-633-7673
Questions, please call: 1-855-344-0930
24 hours a day 7 days a week
TTY users call: 711

Important Information about Prescription Drug Coverage

To: From:

Fax: Pages:

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

- Please complete the attached Request for Coverage of a Non-Formulary Drug Form
- To prevent delays in the review process please complete all requested fields.
- Completed forms should be faxed to: 1-855-633-7673. It is not necessary to fax this cover page.

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

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 the highest brand tier 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.

Health Choice Generations Utah HMO D-SNP is a Health Plan with a Medicare contract and a contract with the state Medicaid program. Enrollment in Health Choice Generations Utah HMO D-SNP depends on contract renewal.

Member privacy is important to us. Our employees are trained regarding the appropriate way to handle our members' private health information.

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Request for Coverage of a Non-Formulary Drug

☐ Request Expedited Review

Patient Information

Name: _____
Member ID: |_|_|_|_|_|_|_|_|_|_|
Medicare ID: |_|_|_|_|_|_|_|_|_|_|
Date of Birth: ___/___/___ Sex: M / F (Circle One)
Address: _____
City: _____
State: _____ Zip: _____
Phone: _____
Nursing Home Resident? YES / NO (Circle One)
Home Care Patient? YES / NO (Circle One)

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: _____ Drug Requested: Brand / Generic (Circle One)
Strength: _____ Dosage: _____ 30 Day Qty.____ Drug: Newly Prescribed / Refill (Circle One)
Directions: _____ Diagnosis: _____

ICD-10 Code: _____ Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review time frame will seriously jeopardize the health of your patient. To request an expedited review, simply indicate at the top of this page.

Request for Coverage of a Non-Formulary Drug Criteria

Medical Justification: Please provide medical justification for the non-formulary drug exception request. Please address why all formulary alternatives on any tier of the formulary for treatment of the same condition would not be effective or would cause adverse effects. 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.

☐ If all formulary agents would not be effective, please specify prior treatment failures.

_____

_____

☐ If all formulary agents would have adverse effects, please specify prior adverse effect history.

_____

_____

☐ If patient preference for nonformulary drug, please provide your clinical rationale.

_____

_____

☐ If no available formulary alternatives have been previously tried, please check this box.

I attest that the information provided on this form is true and accurate as of this date.

Prescriber's Signature _____ **Date:** _____