

SPECIALTY DRUG REQUEST FORM

Once completed, please fax this form to **1-866-240-8123**.

To view our formularies on-line, please visit our Web site at the addresses listed above. Please use a separate form for each drug. Print, type or WRITE LEGIBLY and complete form in full. If approved, the payor will forward to the exclusive specialty vendor.

PRESCRIPTION INFORMATION			
Subscriber ID Number		Highmark Coverage <input type="checkbox"/> MA-PD <input type="checkbox"/> PDP	Group Number
Patient Name		Phone Number	Date of Birth
Patient Address		City	State Zip Code
Drug name (<u>only</u> specialty drugs)		Strength or Dose	Requested Quantity per Month
Directions			
Refills	Date Rx needed	Ship to (please check one) <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other _____	
Diagnosis			
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
Name of Carrier who paid for Most Recent Transplant			
Physician Signature (required)		DEA	Date
ALTERNATIVES TRIED / USED BY PATIENT IF APPLICABLE			
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
MEDICARE	COMMERCIAL	REQUEST TYPE	
<input type="checkbox"/> Tiering Exception <input type="checkbox"/> Non-Formulary <input type="checkbox"/> Prior Authorization	<input type="checkbox"/> Non-Formulary <input type="checkbox"/> Prior Authorization	<input type="checkbox"/> Standard Request <input type="checkbox"/> Expedited Request	<input type="checkbox"/> Peer to Peer <input type="checkbox"/> Expedited Appeal <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 Web site at: <http://mydrug.fomularies.com>

INSTRUCTIONS FOR COMPLETING THE SPECIALTY DRUG REQUEST 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 identified below is required:

NON-FORMULARY

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

SPECIALTY DRUGS REQUIRING PRIOR AUTHORIZATION

For specialty drugs within the therapeutic categories listed below, the diagnosis, applicable lab data, and additional information may be required. For detailed information regarding Pharmacy policies, please visit the Provider Resource Center via Navinet.

- Anti-rheumatic medications
- Osteoporotic medications
- Growth hormones
- Interferons
- Miscellaneous

Fertility agents, Gleevec, Raptiva, Nexavar, Revlimid, Thalomid, Revatio, Sprycel, Sutent, Tarceva, Tykerb, Zolanza, Kuvan

Important Note: Please use the standard "Prescription Drug Medication Request Form" for all non-specialty drugs that require prior authorization.

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

For other helpful information, please visit:

<http://mydrug.formularies.com>