Please complete ALL information below and fax your request to 1-888-671-5285

Value Formulary Exception Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

What is the patient's diagnosis for the medication being requested (specify all)?

_____

ICD-10 Code(s): _____

Is the requested medication being used to treat the patient's stage four, advanced metastatic cancer or a severe adverse health condition experienced as a result of stage four, advanced metastatic cancer? ❑ Yes ❑ No

NON-FORMULARY EXCEPTIONS [coverage at the appropriate level of cost-share]

Has the patient had an inadequate response or inability to tolerate three formulary alternatives in the same pharmacological class? ❑ **Yes** ❑ **No**

Specify all alternatives**:** _____

NON- PREFERRED DRUG TIER EXCEPTION REQUESTS [Brand medication (or authorized generic) to preferred brand tier or Non-Preferred Generic to generic tier]

Has the patient had an inadequate response or inability to tolerate at least three preferred or generic tier alternatives in the same pharmacological class? ❑ **Yes** ❑ **No**

Specify all alternatives**:** _____

CHIP [CHILDREN'S HEALTH INSURANCE PROGRAM) TIER EXCEPTION REQUESTS

Has the patient had an inadequate response or inability to tolerate at least three generic alternatives in the same pharmacological class? ❑ **Yes** ❑ **No**

Specify all alternatives**:** _____

NON-PREFERRED COMPOUNDED PRODUCT TIER EXCEPTION

Has a prior authorization been approved for this compound? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response or inability to tolerate/use all other formulary alternatives? ❑ **Yes** ❑ **No**

If **yes,** specify all alternatives**:** _____

NO COST-SHARE EXCEPTION:

Is the drug described as either a preventative medication identified by US Preventative Services Task Force (USPSTF) or Women's Preventative Services provision of the Patient Protection and Affordable Care Act (PPACA)? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response or inability to tolerate the generic equivalent for the drug requested (if available)? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response or inability to tolerate a generic alternative for the drug requested? ❑ **Yes** ❑ **No**

If **yes,** specify all alternatives**:** _____

Has the prescriber provided documentation indicating the requested product is medically necessary? ❑ **Yes** ❑ **No**

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.