

**Important Information about Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

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

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- 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**

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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.**

Johns Hopkins Advantage MD is a Medicare Advantage plan with a Medicare contract offering HMO and PPO products. Enrollment in Johns Hopkins Advantage MD 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.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.



# Request for Coverage of a Non-Formulary Drug

## Patient Information

Name \_\_\_\_\_  
 Member ID \_\_\_\_\_  
 Medicare ID \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Sex: M / F  
 Address \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Phone \_\_\_\_\_  
 Nursing Home Resident? YES / NO  
 Home care patient? YES / NO

## 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 is (circle one): Brand / Generic  
 Strength: \_\_\_\_\_ Dosage form: \_\_\_\_\_ Qty per 30 days: \_\_\_\_\_ Drug is (circle one): Newly prescribed/Refill  
 Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-9 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 this 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:** \_\_\_\_\_