JOHNS HOPKINS
HEALTH PLANS

Fax completed form to: 1-855-633-7673
Questions, please call: 1-877-293-5325
24 hours a day 7 days a week
(TTY users call: 711)

Advantage MD - Important Information about Prescription Drug Coverage

To: From:

Fax: Pages:

Re: Request for a Lower Copay (Tiering Exception): Please respond.

- Please complete the attached Request for a Lower Copay* (Tiering Exception
- Form)
- To prevent delays in the review process please complete all requested fields.

Completed forms should be faxed to1-855-633-7673. It is not necessary to fax this cover page.

Information about this Request for a Lower Copay (Tiering Exception)

Use this form to request coverage of a brand or generic in a higher cost sharing tier at a lower cost sharing tier. Certain restrictions apply.

To process this request, documentation that all of drugs to treat the same medical condition on the lower cost sharing tier would not be as effective or would have adverse effects must be provided. Please provide clinical information or other evidence to support the medical necessity of the drug on the higher cost sharing tier, including previous drugs attempted for this patient's condition. Please note: **Tiering exceptions cannot be requested for non-formulary drugs approved under the formulary exception process, drugs in the specialty tier, or brand-name drugs at the price of a generic drug.**

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 PPO plan with a Medicare contract. Enrollment in Johns Hopkins Advantage MD depends on contract renewal.

*Copay, copayment or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

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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Advantage MD - Request for a Lower Copay (Tiering Exception)

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 a Lower Copay (Tiering Exception) Criteria

Medical Justification: Please provide medical justification for requesting a lower copay (tiering exception) for a brand or generic drug in a higher cost-sharing tier. Please address why all formulary alternatives on any lower 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 lower-tier agents would not be effective, please specify prior treatment failures:_____
_____
_____
_____

☐ If all lower-tier agents would have adverse effects, please specify prior adverse effect history:_____
_____
_____
_____

☐ If patient preference for higher-tier drug, please provide your clinical rationale:_____
_____

☐ If no available lower-tier 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:** _____