PRIOR AUTHORIZATION REQUEST

Global Non-Formulary Criteria

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip__
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1. ❑ Yes ❑No Is the requested medication prescribed for an oncology-related condition (such as cancer, leukemia, myelodysplastic syndrome or supportive medications such as anti-emetics or colony-stimulating factors)?
   If the answer to this question is YES, then no further questions required. For oncology-related diagnosis, please obtain authorization through Eviti Oncology Service at 1-888-678-0990, or www.Eviti.com
2. ❑ Yes ❑No Is the requested medication a mental health medication?
   If the answer to this question is YES, then no further questions required. Mental health conditions are covered by the state. The pharmacy should process the prescription through the mental health pharmacy vendor, Xerox/ACS, bin #610084.
3. ❑ Yes ❑No Is this a RENEWAL request for a previous authorization of this medication?
4. ❑ Yes ❑No If **Yes** to the previous question, is the patient responding to therapy with the requested medication?
5. Please document the diagnosis or indication for the requested medication and the dose based on the patient's age and indication ***(please document below):***

_____

_____

6. ❑ Yes ❑No Does the patient have an appropriate diagnosis or indication for the requested medication?
7. ❑ Yes ❑No Is the dose of the requested medication appropriate, based on the patient's age and indication?
8. ❑ Yes ❑No Did the patient experience intolerance or adverse side effect to the generic formulations made by TWO different manufacturers?
9. ❑ Yes ❑No Did the patient experience a treatment failure with a trial of generic formulations made by TWO different manufacturers?

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If you have any questions, call: 800-753-2851

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10. ❑Yes ❑No Has a MedWatch Form 3500 been completed and submitted with this request? ***NOTE: The MedWatch form can be obtained from: http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf***
11. Please provide the names of ALL medications that are contraindicated based on the patient's diagnosis, other medical conditions, or other medication therapy. *Please Note: The type of contraindication must be included for each medication (such as drug allergy or serious drug interaction).*

12. Please provide the names of ALL medications that the patient has tried. *Please Note: For each medication, include whether it is current or past treatment, and the DATES and DURATION of therapy with each of these agents.*

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

If you have any questions, call: 800-753-2851