# NON-FORMULARY PRIOR AUTHORIZATION REQUEST

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)? **Please note: For oncology-related diagnosis the authorization must be obtained through Eviti Oncology Service at 1-888-678-0990, or www.Eviti.com.**

2. ☐ Yes ☐ No Is the requested medication for the treatment of mental health? **Please note: Medications for 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 the requested medication prescribed for the treatment of hepatitis C? **Please call Maryland Physicians Care at 1-800-953-8854 for coverage review.**

4. Is this a RENEWAL request for a previous authorization of this medication?
   - ☐ Yes - **please answer question 5 only**
   - ☐ No - **please answer questions 6 - 15**

5. ☐ Yes ☐ No Is the patient responding to therapy?

6. Please document the diagnosis and dose for the requested medication based on the patient's age and indication_____

7. Please document any other medications tried for this diagnosis and the reason for treatment failure. (Type N/A if patient has not tried other medications for this diagnosis.)

_____

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

# NON-FORMULARY PRIOR AUTHORIZATION REQUEST

8. Please document all drug interactions and/or adverse experiences with other medications with the same indication as the requested product. (Type N/A if the patient does not have drug interactions or an adverse experience.)

_____

9. Did the patient experience intolerance, adverse side effect, or treatment failure to the generic formulations made by TWO different manufacturers?
   - ☐ Yes
   - ☐ No therapeutically equivalent generic is available
   - ☐ No

10. ☐ Yes ☐ No Has a MedWatch Form 3500 been completed and submitted with this request? Please Note: The MedWatch form can be obtained from http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf
11. ☐ Yes ☐ No Does the patient have an appropriate diagnosis or indication for the requested medication?
12. ☐ Yes ☐ No Is the dose of the requested medication appropriate, based on the patient's age and indication?
13. ☐ Yes ☐ No Are there other medications available on the formulary to treat the patient's condition?
14. ☐ Yes ☐ No Has the patient tried at least TWO formulary agents IN THE SAME DRUG CLASS (if two formulary agents are available) as the requested medication?
15. ☐ Yes ☐ No Does the patient have a contraindication, such as drug allergy or serious drug interaction, to the preferred formulary alternatives?

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

***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**

# NON-FORMULARY PRIOR AUTHORIZATION REQUEST

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.



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