PRIOR AUTHORIZATION GLOBAL EXCEPTION 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. Please provide the patient's diagnosis or indication, current weight in kg, prescribed strength and dose per mg, frequency, route of administration (for example, oral, topical, subcutaneous, intravenous, etc.), and number of courses requested (if applicable). Indicate if the dose is adjusted for the patient's condition or other patient specific considerations.

2. ☐ Yes ☐ No Is this a RENEWAL request for a previous authorization of this medication?
   If "Yes" please answer questions 3 – 4 & 11. If "No" please answer questions 5–11.
3. ☐ Yes ☐ No Is the patient responding to therapy with the requested medication?
4. ☐ Yes ☐ No Is this a request for MAINTENANCE therapy?
5. Is this request for a brand or generic medication?
   ☐ Brand → **please answer questions 6–11**
   ☐ Generic → **please answer questions 9–11**
6. Did the patient experience intolerance or adverse side effect to the generic formulations made by TWO different manufacturers?
   ☐ Yes
   ☐ No therapeutically equivalent generic is available
   ☐ No
7. Did the patient experience a treatment failure with a trial of generic formulations made by TWO different manufacturers?
   ☐ Yes
   ☐ No therapeutically equivalent generic is available
   ☐ No

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

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8. □ Yes □ No Has a MedWatch Form 3500 been completed and submitted with this request?
9. Please document ALL of the other medications the patient has tried for their condition. For each medication, include whether it is current or past treatment, and the DATES and DURATION of therapy with each of these agents.

10. Please document ALL of the medications that are contraindicated based on the patient's diagnosis, other medical conditions, or other medication therapy. The type of contraindication must be included for each medication (such as drug allergy or serious drug interaction).

11. □ Yes □ No Does the patient have an appropriate diagnosis?

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

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SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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