

PRESCRIPTION DRUG MEDICATION REQUEST FORM FAX TO 1-866-240-8123



Fax each form separately. Please use a separate form for each drug.
 Print, type or write legibly in blue or black ink. *See reverse side for additional details*

PATIENT INFORMATION			
Subscriber ID Number		Highmark Coverage <input type="checkbox"/> MA-PD <input type="checkbox"/> PDP	
Group Number			
Patient Name		Patient Telephone Number	Date of Birth
Patient Address		City	State Zip Code
CLINICAL / MEDICATION INFORMATION			
Drug Name		Strength or Dose	Requested Quantity per Month
Diagnosis		Name of the Carrier who paid for Most Recent Transplant	
Type of Transplant <input type="checkbox"/> Lung <input type="checkbox"/> Heart <input type="checkbox"/> Kidney <input type="checkbox"/> GVH <input type="checkbox"/> Other		Date of Most Recent Transplant	Most Recent Transplant Payer (check one) <input type="checkbox"/> Commercial <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Medicare FFS
Alternatives Tried / Used By Patient (if applicable)			
Drug Name	Strength	Documentation of Failure of Therapy	
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Drug Name	Strength	Documentation of Failure of Therapy	
Medical Rationale / Reason for Drug Therapy / Treatment Plan			
PHYSICIAN INFORMATION (needed for mailing notification - please print legibly)			
Physician Name		NPI or Tax ID # (Required)	Phone Fax
Physician Address		City	State Zip Code
Suite / Building		Physician Signature	
		Date	
MEDICARE		COMMERCIAL	
<input type="checkbox"/> Tiering Exception		<input type="checkbox"/> Non-Formulary	
<input type="checkbox"/> Non-Formulary		<input type="checkbox"/> Prior Authorization	
<input type="checkbox"/> Prior Authorization			
REQUEST TYPE			
<input type="checkbox"/> Standard Request		<input type="checkbox"/> Peer to Peer	
<input type="checkbox"/> Expedited Request		<input type="checkbox"/> Expedited Appeal	
		<input type="checkbox"/> Standard Appeal	

Once a clinical decision has been made, a decision letter will be mailed to the patient and physician.
 For other helpful information, please visit the Highmark Web site at:

www.highmark.com

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.
NOTE: The prescribing physician (PCP or Specialist) should, in most cases, complete the form.
3. Please provide the physician address as it is required for physician notification.
4. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
Or mail the form to: **Clinical Services,
120 Fifth Avenue, MC P4207, Pittsburgh, PA 15222**

CLINICAL SERVICES PROCEDURES

In general, when requesting coverage for a medication, the following information in the bullet points below is required:

NON-FORMULARY

- Most products: documentation of a trial of at least two formulary products

PRIOR AUTHORIZATION

Below is a list of common drugs and/or therapeutic categories that require prior authorization:

- Agents used for fibromyalgia (e.g. Cymbalta, Lyrica, Savella)
- Testosterone therapies
- Miscellaneous Items: contraceptives, Provigil, immediate release fentanyl products
- Specialty drugs (e.g. Enbrel, Sutent, Tracleer, etc.)

MANAGED PRESCRIPTION DRUG COVERAGE (MRXC)

The MRXC program includes coverage for specific drug therapy categories with set thresholds or limits. The MRXC program uses specific criteria as set forth by Pharmacy and Therapeutics Committee to assess the information provided to support requests for additional quantities.

Below is a list of common drugs and/or therapeutic categories that are managed under our MRXC program:

- Medications used to treat Migraines (e.g. Amerge, Imitrex, Maxalt, etc.)
- Medications used to treat Onychomycosis (Lamisil and Sporanox)
- Leukotriene Modifiers (Singulair, Accolate, and Zylflo)
- Pain Management (OxyContin, Opana ER, etc.)

Please note that the drugs and therapeutic categories managed under our Prior Authorization and MRXC programs are subject to change based on the FDA approval of new drugs.

HIGHMARK MEDICARE-APPROVED FORMULARIES

Additional drugs and/or therapeutic categories that require prior authorization and the required information are listed below.

- Immunosuppressants: diagnosis and/or documentation of Medicare-approved organ transplant
- Methotrexate (oral): diagnosis
- Intravenous immune globulins: diagnosis and place of service

Categories of Drug Management is subject to change. For a comprehensive view of the Medicare Approved Formulary, please visit <https://hbs.highmarkprc.com/Pharmacy-Program-Formularies/Medicare-Formularies>

For a complete list of services requiring authorization, please access the Authorization Requirements page on the Highmark Provider Resource Center under Claims, Payment & Reimbursement > Procedure/Service Requiring Prior Authorization or by the following link: <https://hbs.highmarkprc.com/Claims-Payment-Reimbursement/Procedure-Service-Requiring-Prior-Authorization>