HIGHMARK WHOLECARE

**REQUEST FOR DRUG COVERAGE**
**FAX COMPLETED FORM TO: (888) 447-4369**

Failure to complete this form in its entirety may result in an adverse coverage determination due to lack of information.

| MEMBER INFORMATION | | | |
|---|---|---|---|
| First Name: | Last Name: | Date of Birth: | Member ID: |
| Weight: | Height: | Drug Allergies: | Type of Reaction(s): |

| DRUG INFORMATION | | | |
|---|---|---|---|
| ☐ **FOR ONCOLOGY USE** | | | |
| Drug Name: | Strength & Route: | Frequency: | Quantity: |
| ☐ New Prescription<br>☐ Existing Therapy | Date Initiated: | Was medication initiated in hospital? ☐ Yes ☐ No | Expected Length of Therapy: |
| Diagnosis: | | ICD Code: | |

**BILLING INFORMATION**

This medication will be billed: ☐ At a pharmacy **OR** ☐ Medically, JCODE: _____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Facility NPI:_____

**TYPE OF REQUEST**

☐ Request for prior authorization or step therapy for the prescribed drug
☐ Request for an exception to existing criteria (prior authorization or step therapy exception)
☐ Request for a drug that is not on the list of covered drugs (formulary exception)
☐ Request for an exception to the limit on the number of doses (quantity limit exception)
☐ Request for a lower copayment (tiering exception)
☐ Other (please specify):

☐ **Request for Expedited Review:** By checking this box and signing below, I certify that applying the 72 hour review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

**SUPPORTING STATEMENT**

When requesting an exception, the prescribing physician **must** provide a supporting statement indicating why the requested prescription drug is medically necessary and formulary alternatives OR the number of doses available under a dose restriction have been or are likely to be ineffective, adversely affect patient compliance, or cause an adverse reaction. **Please provide the supporting statement below and attach any additional supporting information (i.e. chart documentation).**

_____
_____
_____
_____

**FORMULARY ALTERNATIVES TRIED**

| Drug Name/Strength: | Dates Tried: | Reason for discontinuation: |
|---|---|---|
| | | |
| | | |
| | | |

| PRESCRIBER INFORMATION | | |
|---|---|---|
| Prescriber Name (printed): | Specialty: | NPI Number: |
| Prescriber Address: | | |
| Office Phone: | Office Fax: | |
| Prescriber Signature: | Date: | |

MAY PHOTOCOPY FOR OFFICE USE

*Information on this form is protected health information and subject to all privacy and security regulations under HIPAA*

If you need to speak to a Pharmacy Services Representative, call 1-800-685-5209. Formulary information can be found at https://highmarkwholecare.com/Medicare/Member-Tools/Medication-Benefits/Formulary-Medication