HEALTHY U CHIP

FORMULARY EXCEPTION REQUEST FORM

For an exception consideration, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Member Information	Prescriber Information
Member Name:	Prescriber Name and Specialty:
Member ID#:	Prescriber NPI#:
Member Date of Birth:	Prescriber Office Phone:
Member Phone:	Prescriber Secure Fax:
Member Drug Allergies:	Prescriber Office Contact:

Diagnosis and Medical Information	
Drug Name and Strength Requested:	Diagnosis & ICD Code:
Dosing Instructions:	Quantity per 30 Days:

Questions	Yes	No
1. Is the requested medication being purchased by the provider's office and to be billed under the medical benefit ('buy-and-bill')?	☐	☐
2. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review, you are certifying that applying the standard review time frame may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐
3. Does clinical documentation support that one of the following has been met? a. Evidence provided to show the member has failed or has a contraindication to all FDA-indicated formulary and/or guideline recommended options, OR b. That the requested therapy has clinically significant superior efficacy for the member condition compared to formulary options, (as evidenced by randomized, controlled, clinical trials and applicable clinical guidelines); OR c. The requested medication meets medical necessity and is the only treatment option for the member's condition;	☐	☐
4. Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	☐	☐
5. Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	☐	☐

Previous Formulary Trial(s)		
Drug Name/Strength Dosage	**Date(s) and Duration of Trial**	**Treatment Outcome**

Request Rationale	
History of a medical condition, allergies or other pertinent information requiring the use of this medication: _____ _____ _____ _____ _____ _____ _____	
Prescriber Signature:	Date:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****