09/23/2013

HMSA Quest (Medicaid)

HMSA QUEST (MEDICAID)

Formulary Exception (Clinical)

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-855-762-5206**.

Please contact CVS/Caremark at **1-855-220-5732** with questions regarding the HMSA Quest (Medicaid) process.

When conditions are met, we will authorize the coverage of Formulary Exception (Clinical).

Drug Name (select from list of drugs shown)

Other, Please Specify

Quantity _____ **Frequency** _____ **Strength** _____

Route of Administration _____ **Expected Length of Therapy** _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested non-formulary drug a topical testosterone product? Y N

   [If the answer to this question is yes, skip to question 3.]

2. Is the requested non-formulary drug a controlled substance (that is, Schedule II, III, IV, or V)? Y N

   [If the answer to this question is yes, then no further questions are required.]

3. Does the requested non-formulary drug have a generic equivalent available? Y N

   [If the answer to this question is yes, then no further questions are required.]

4. Is the non-formulary drug being used for an FDA approved indication? Y N

   [If the answer to this question is no, then no further questions are required.]

5. Does the patient have medical record documentation indicating intolerance OR ineffective treatment response OR allergy to at least TWO of the formulary alternatives in the same category/class of drugs? Y N

   [If the answer to this question is yes, then no further questions are required.]

6. Does the patient have medical record documentation indicating that all comparable formulary agents are contraindicated based on the patient's diagnosis, other medical conditions, or other medication therapy? Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date