hmsa

An Independent Licensee of the Blue Cross and Blue Shield Association

07/19/2015

Prior Authorization Form

HMSA Essential Prescription Formulary Non-Formulary Exception Form

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 **1-855-762-5207**.
Please contact CVS/Caremark at **1-855-240-0543** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Non-Formulary Exception.

Drug Name

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 drug being used for an FDA-Approved indication OR an indication supported in the compendia of current literature with a II A/2A or above recommendation (examples: AHFS, Micromedex, NCCN)?	Y N
2.	Does the patient have legible medical record documentation indicating intolerance OR ineffective treatment response OR allergy to ALL formulary alternatives (including over-the-counter options) in the same/similar category/class of drugs? Drug Name_____ Trial Year_____ Reason for Failure_____ Drug Name_____ Trial Year_____ Reason for	Y N _____

Failure_____ Drug Name_____ Trial Year_____ Reason for Failure_____ Drug Name_____ Trial Year_____ Reason for Failure_____	_____
[Note: For combination products, member must try/fail all formulary alternatives for the individual components.]	
[If yes, then skip to question 4. Documentation is required for approval. Copy of clinical notes required.]	
3. Does the patient have medical record documentation indicating that ALL comparable formulary agents (including over the counter options) are contraindicated based on the patient's diagnosis, other medical conditions, or other medication therapy? Reason(s) the patient cannot try the formulary alternatives:	Y N _____
[If yes, then documentation is required for approval. Copy of clinical notes required.]	
4. Does the requested non-formulary drug have a generic equivalent available?	Y N
[If no, then no further questions.]	
5. Has the patient experienced an intolerance OR ineffective treatment response OR allergy with the generic alternative documented in the medical record?	Y N
[Note: GI upset or irritation is not generally considered an allergy or failed treatment. Common documented side effects attributed to the drug (i.e., headache, nausea, muscle aches, fatigue, etc) are not considered an allergy and would be expected to occur at a similar level in both the generic and brand agents.]	
6. Has the prescriber determined and documented in the medical record that the generic alternative is contraindicated based on the patient's diagnosis, other medical conditions, or other medication therapy? [If yes, then provider must submit a completed FDA MedWatch for (http://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Forms/UCM163919.pdf) documenting the intolerance or lack of efficacy of the generic product. The completed form must be faxed to the FDA for reporting of adverse events and product problems.	Y N

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

Prescriber (Or Authorized) Signature **Date**