



REQUEST FOR A NON-FORMULARY PRIOR AUTHORIZED DRUG EXCEPTION OR STEP THERAPY

Member Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Member ID number: \_\_\_\_\_ Date: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Is this an appeal to a previously denied request? YES or NO (A separate request must be completed for each patient for whom the following drug is prescribed. This form does not constitute a request for addition of this drug to the drug formulary.)

Drug Requested (Generic and/or Brand name) \_\_\_\_\_

Dose Prescribed, Dosage Form, Frequency of Dose \_\_\_\_\_ Quantity Prescribed \_\_\_\_\_

Expected Duration of Therapy: \_\_\_\_\_

Reason(s) Drug is Requested: \_\_\_\_\_

Other Formulary Drugs Tried, and Results of Treatment: \_\_\_\_\_

Dispensing Pharmacy \_\_\_\_\_ Fax Number \_\_\_\_\_

I understand the above drug may not be on the current Independent Health Drug Formulary. Further, I understand that if this request is not approved, the patient will be responsible for paying the entire cost of the medication if it is prescribed.

MD Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Provider I.D. Number: \_\_\_\_\_

Print Name: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Contact Person (if additional information is necessary) \_\_\_\_\_

\*\*\*Do Not Write Below This Line (Internal Use only)\*\*\*

Date/Time Received \_\_\_\_\_ Plan Code: \_\_\_\_\_ Drug Code: \_\_\_\_\_ LOB: \_\_\_\_\_ Case #: \_\_\_\_\_

- Approved
Approved with Modifications
Denied
Does not require Prior Authorization (Contractual)
Other Explanation:

Medical Director and/or Pharmacist, Independent Health Association \_\_\_\_\_ Date/Time of Decision \_\_\_\_\_

Approval does not guarantee payment; Approval is subject to the terms of the member's contract. For questions regarding non-formulary/prior authorization requests or if the treating physician would like to discuss this case with a physician reviewer, please call the pharmacy department at (716) 631-2934 or (800) 247-1466 x 5311 between the hours of 8:00 am and 11:00 PM Monday - Friday, 8:00 AM and 8:00 PM Saturday and Sunday.

If you disagree with this decision you have the right to file an expedited or standard appeal by contacting the Pharmacy department at (716) 631-2934, or the member may appeal to member services at:

Independent Health (716) 631-8701 or (800) 501-3439

OR

Pharmacy Benefit Dimensions (716) 635-7880 or (888) 878-9172.

Form may be mailed to: Independent Health Association Attn: Pharmacy Department 511 Farber Lakes Drive Buffalo, NY 14221

or Faxed to: (716) 631-9636, OR (716) 631-0149, OR (800) 273-7397

Confirmation to MD (Date/Time): Fax: \_\_\_\_\_ Phone: \_\_\_\_\_ Mail: \_\_\_\_\_