Independent Health

Independent Health's
Pharmacy Benefit Dimensions

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 Expiration Date:_____
_____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: _____