AdventHealth Specialty Formulary Exception/Prior Authorization Request Form

Patient Information			Prescriber Information		
Patient Name:	DOB:		Prescriber Name:	NPI#	
Patient ID#:			Address:		
Address:			City:	State:	Zip:
City:	State:	Zip:	Office Phone #:	Secure Office Fax #:	
Home Phone:	Gender: M or F		Contact Person at Doctor's Office:		

Drug Information			
Medication and Strength:	Directions for use (Frequency):		Expected Length of Therapy:
Qty:	Day Supply:	ICD10 Code/Diagnosis:	Route of Administration:

PLEASE PROVIDE ALL RELEVANT CLINICAL DOCUMENTATION TO SUPPORT USE OF THIS MEDICATION
Solely providing demographic and drug information may not constitute a sufficient request for coverage.

☐ **Expedited/Urgent Review Requested:** *By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.*

Continuation of Therapy:

1. Has the patient been receiving the requested drug within the last 120 days? ***Yes or No***
2. Has the requested drug been dispensed at a pharmacy and approved for coverage previously by a prior plan? ***Yes or No***
3. How long has the patient been on the requested medication?_____
4. Has the patient had a positive response to treatment or had improvement in symptoms? ***Yes or No***
5. Has the patient's need for continued therapy been assessed within the previous year? ***Yes or No***

Is the requested product being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? ***Yes or No***

Does the prescribed dose/quantity fall within the FDA-approved labeling or dosing guidelines found in the compendia of current literature? ***Yes or No***

Please list ALL medications the patient has tried specific to the diagnosis and specify below**:**

Medication _____Explanation for failure or contraindication _____
Medication _____Explanation for failure or contraindication _____
Medication _____Explanation for failure or contraindication _____
*ALL other medications tried and reasons for failure: _____

Is the request for a patient with a highly sensitive condition (e.g., psychiatric condition, epilepsy, organ transplant) who is stable on the current drug(s) and who might be at high risk for a significant adverse event or harm with a medication change? ***If yes, specify anticipated significant adverse event:***

_____

Does the patient have a chronic condition confirmed by diagnostic testing? ***If yes, please provide diagnostic test and date***: _____

Does the patient require a specific dosage form (e.g., suspension, solution, injection)? ***If yes, please provide dosage form and clinical explanation***:

_____

Does the patient have a clinical condition for which other formulary alternatives are not recommended or are contraindicated due to comorbidities or drug interactions based on published clinical literature? If so, please provide documentation including medication names and clinical reasons.

_____

PRESCRIPTION BENEFIT PLAN MAY REQUEST ADDITIONAL INFORMATION OR CLARIFICATION, IF NEEDED, TO EVALUATE REQUESTS.

PLEASE FAX COMPLETED FORM TO 1-833-896-0648.

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark®, the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. *See, e.g.*, 31 U.S.C. §§ 3729-3733.

Prescriber Signature: _____ **Date**: _____