

Important Information about Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Request for Coverage of a Non-Formulary Drug: Please respond.

- Please complete the attached Request for Coverage of a Non-Formulary Drug Form
- To prevent delays in the review process please complete all requested fields.
- Completed forms should be faxed to: 1-855-633-7673. It is not necessary to fax this cover page.

Information about this Request for Coverage of a Non-Formulary Drug

Use this form to request coverage of a drug that is not on the formulary. To process this request, documentation that all formulary alternatives would not be as effective or would have adverse effects is required. Please provide clinical information or other evidence supporting the medical necessity of the non-formulary drug, including previous formulary drugs attempted for this patient's condition. If the formulary exception is approved, it will be reimbursed at the highest brand tier copay for the calendar year.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

The State of New York has created a participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by MetroPlus FIDA Plan. ICAN may be reached toll-free at 1-844-614-8800 or online at icannys.org.

MetroPlus FIDA Plan (Medicare-Medicaid Plan) is a managed care plan that contracts with both Medicare and the New York State Department of Health (Medicaid) to provide benefits of both programs to Participants through the Fully Integrated Duals Advantage (FIDA) Demonstration.

Benefits, List of Covered Drugs, and pharmacy and provider networks may change from time to time throughout the year and on January 1 of each year.

Member privacy is important to us. Our employees are trained regarding the appropriate way to handle our members' private health information.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Request for Coverage of a Non-Formulary Drug

Patient Information

Name
Member ID
Medicare ID
Date of Birth
Sex: M / F
Address
City
State ZIP
Phone
Nursing Home Resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name
Specialty
DEA
NPI
Address
City
State ZIP
Phone Fax
Pharmacy name
NCPDP
NPI
Phone Fax

All items below this line are for Physician Use Only

Information for Requested Drug

Drug Name: Drug Requested is (circle one): Brand / Generic
Strength: Dosage form: Qty per 30 days: Drug is (circle one): Newly prescribed/Refill
Directions: Diagnosis:
ICD-10 Code: Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review time frame will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Request for Coverage of a Non-Formulary Drug Criteria

Medical Justification: Please provide medical justification for the non-formulary drug exception request. Please address why all formulary alternatives on any tier of the formulary for treatment of the same condition would not be effective or would cause adverse effects. List previous drugs and doses attempted for this patient, condition and dates or approximate dates or duration of treatment (if known). Document adverse effects requiring discontinuation and/or reason for perceived ineffectiveness. Attach additional pages if necessary.

- If all formulary agents would not be effective, please specify prior treatment failures:
If all formulary agents would have adverse effects, please specify prior adverse effect history:
If patient preference for nonformulary drug, please provide your clinical rationale:
If no available formulary alternatives have been previously tried, please check this box.

I attest that the information provided on this form is true and accurate as of this date:

Prescriber's signature: Date: