



Phone: 866-643-6681



MEDICATION EXCEPTION REQUEST FORM

Date of Submission:

Action Needed: Routine Urgent Emergent

Request for all other medications: <input type="checkbox"/> Verbal Prior Authorization may be processed by calling 1-866-643-6681 *** Hepatitis C and Growth Hormone medications are not available via the verbal PA process. OR <input type="checkbox"/> Fax	<input type="checkbox"/> Request for any medication below:			
	Actemra	Leukine	Procrit	Synagis
	Aranesp	Lupron Depot	Remicade	Tysabri
	Cinryze	Neumega	Rituxan (RA)	Xolair
	Epogen	Neupogen	Soliris	
	Intron-A	Nplate	Stelara	
	IVIG	Orencia	Supprelin LA	
• Complete and fax to Catalyst Rx at 888-800-9602		• Complete and fax to AvMed at 800-552-8633		

PATIENT INFORMATION			
Member ID	Date of Birth	Is Member Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Member Name	Height	Weight	
Diagnosis	Diagnosis (ICD-9) Code		

DELIVERY INFORMATION: PLEASE CHECK APPLICABLE BOX	
<input type="checkbox"/> In-office (MD to supply and administer)	<input type="checkbox"/> CuraScript – patient delivery (home health)
<input type="checkbox"/> Retail pharmacy Pickup	<input type="checkbox"/> CuraScript – patient delivery (self inject)
<input type="checkbox"/> Facility (i.e. out-patient)	<input type="checkbox"/> CuraScript – MD office delivery
• Facility Name / AvMed ID _____	

ADDITIONAL MEDICATION INFORMATION			
Drug Name	Quantity		
Directions for Use	<input type="checkbox"/> New Therapy <input type="checkbox"/> Continuation of Therapy		
If Continuation of therapy, indicate the member's therapeutic response:			
Duration of Therapy	Procedure Code		
Reason for Request			

ADDITIONAL MEDICAL INFORMATION
Please list alternative therapies previously tried and failed, including dose, length of therapy and adverse outcome:
MUST ATTACH OFFICE NOTES AND CURRENT LAB RESULTS.
<i>Incomplete forms and/or inadequate documentation may result in denial.</i>

PHYSICIAN INFORMATION			
Physician Name	Physician Specialty		
NPI #	AvMed Provider #		
Phone Number	Fax Number		
Office Contact Name	Physician Signature		

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PROTON PUMP INHIBITORS, ARBS, STATINS, CELEBREX

List alternative therapies previously tried and failed, including dose, length of therapy and adverse outcome:

Blank lines for text entry.

SPORANOX, PENLAC

Provide lab exam results that confirm presence of dermatophytes & documentation of other underlying conditions/diagnoses present:

Blank lines for text entry.

ANDRODERM, ANDROGEL

Provide lab exam results with baseline testosterone levels:

Blank lines for text entry.

RESTASIS

List alternative therapies previously tried and failed as well as prescribing physician specialty:

Blank lines for text entry.

TOPAMAX

Provide diagnosis and documentation of successful therapy:

Blank lines for text entry.

CIMZIA, ENBREL, HUMIRA (PREFERRED), SIMPONI (PREFERRED)

Provide diagnosis, progress notes, appropriate labs (if applicable), previous tried/failed therapies and documentation of successful therapy:

Blank lines for text entry.

RIBAVIRIN AND PEG-INTRON (HEP C MEDS) NOT AVAILABLE BY VERBAL PA

Provide lab results (HCV RNA viral load, liver biopsy, liver enzymes, INR and genotype); medications to be reviewed together:

Blank lines for text entry.

Request for all other medications:

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Fax

• Complete and fax to Catalyst Rx at 888-800-9602

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