



Phone: 866-643-6681



# MEDICATION EXCEPTION REQUEST FORM

Date of Submission:

Action Needed:  Routine  Urgent  Emergent

<b>Request for all other medications:</b>  <input type="checkbox"/> <b>Verbal Prior Authorization may be processed by calling 1-866-643-6681</b>  <b>*** Hepatitis C and Growth Hormone medications are not available via the verbal PA process.</b>  <b>OR</b>  <input type="checkbox"/> <b>Fax</b>	<input type="checkbox"/> <b>Request for any medication below:</b>			
	Amevive	IVIG	Nplate	Soliris
	Aranesp	Leukine	Orencia	Stelara
	Cimzia	Lupron Depot	Procrit	Supprelin LA
	Cinryze	Mozobil	Remicade	Synagis
	Epogen	Neumega	Rituxan (RA)	Tysabri
	Intron-A	Neupogen	Sandostatin	Xolair
<b>• Complete and fax to Catalyst Rx at 888-852-1832</b>		<b>• Complete and fax to AvMed at 800-552-8633</b>		

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
<b>• Facility Name / AvMed ID _____</b>	

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:
<b>MUST ATTACH OFFICE NOTES AND CURRENT LAB RESULTS.</b> <b>Incomplete forms and/or inadequate documentation may result in denial.</b>

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/LAMISIL/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.

**ENBREL, HUMIRA**

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

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