COMMERCIAL MEDICATION EXCEPTION REQUEST FORM 2016

Date of Submission: _____

☐ **All Medications listed in the table require a PA. Please include Office Notes and Labs with all requests**

☐ **Request for all other medications:**

Complete and fax to AvMed to:

1-877-535-1391

+Abraxane	+Carimune NF	+Gammagard	Kadcyla	Nplate	Provenge	+Treanda
+Actemra	Cinryze	+Gammagard SD	Kanuma	Nucala	+Remicade	Tysabri
Acthar	Darzalex	+Gammaplex	Keytruda	Odomzo	Remodulin	+Vectibix
+Adcetris	Empliciti	+Gamunex	Krystexxa	+Octagam	+Rituxan	Xiaflex
+Alimta	+Epogen	+Halaven	Kyprolis	Onivyde	Ruconest	Xolair
+Aloxi	epoprostenol (Flolan)	+Herceptin	+Leukine	Opdivo	Simponi Aria	+Yervoy
+Aranesp	+Erbitux	Imlygic	+Lupron Depot	+Orencia IV	+Soliris	Yondelis
+Avastin	Erwinaze	Intron-A	+Neulasta	+Perjeta	+Stelara	+Treanda
Benlysta	+Flebogamma	+IVIG	Neumega	+Privigen	Supprelin LA	
Botulinum toxin	+Fusilev	+Jevtana	+Neupogen	+Procrit	Synagis	

***(+)** Please contact Magellan Rx Management at 800-424-1740 or www.MagellanRx.com for PA on MD office administered drugs indicated with an **(+)**. Please complete and fax this form to AvMed at 877-535-1391 for all other medications.*

Please include all notes and Labs

PATIENT INFORMATION

Member ID		**Date of Birth**		**Is Member Pregnant?** ☐ **Yes** ☐ **No**	
Member Name		**Height**		**Weight**	
Diagnosis		**Diagnosis (ICD-10) Code**			

DELIVERY – ADMINISTRATION INFORMATION

☐ **In-office (MD to supply and administer)**

☐ **Retail pharmacy Pickup**

☐ **Home Health Provider**

☐ **Outpatient Facility** ☐ **Infusion Suite**

Name of Facility/Suite: _____

Facility/Suite Provider Number: _____

If you are requesting medication delivery to your office, enrollment in the CVS Specialty Medication Delivery Program is required.

Please choose below:

☐ **CVS Specialty – Patient delivery (self-administered specialty meds)**

☐ **CVS Specialty – MD office delivery**

CVS Specialty can be reached at :
Phone: 866-638-8311 Fax:800-323-8311

ADDITIONAL MEDICATION INFORMATION

FAX 877-535-1391

Please attach all Office Notes and Current Lab Results

Incomplete forms and/or inadequate documentation may result in a denial

Drug Name		**Quantity**	
Directions for Use		☐ **New Therapy**	☐ **Continuation of Therapy**

If Continuation of Therapy, indicate the member's therapeutic response:

Duration of Therapy		**Procedure Code**	
Reason for Request			

PHYSICIAN INFORMATION

Prescriber Name		**Prescriber Specialty**		
Form Completed By		**AvMed Provider #**		
NPI #		**Office Number**		**Ext**
Contact Name		**Fax Number**		