# FORMULARY EXCEPTION
## PRIOR AUTHORIZATION/MEDICAL NECESSITY DETERMINATION
PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

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**PATIENT AND INSURANCE INFORMATION** **Today's Date:** _____

| | | | |
|---|---|---|---|
| Patient Name (First): | Last: | M: | DOB (mm/dd/yyyy): |
| Patient Address: | City, State, Zip: | Patient Telephone: | |
| Member ID Number: | Group Number: | | |

**PRESCRIBER/CLINIC INFORMATION**

| | | | |
|---|---|---|---|
| Prescriber Name: | Prescriber NPI#: | Specialty: | Contact Name: |
| Clinic Name: | Clinic Address: | | |
| City, State, Zip: | Phone #: | Secure Fax #: | |

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient diagnosis (ICD code and description):

Medication requested: Strength:

Dosing schedule: Quantity per month:

1. Is the patient currently treated with the requested agent? ☐ Yes ☐ No
2. Is the requested agent being used for contraception? ☐ Yes ☐ No
   If yes, has the patient tried and had an inadequate response to a formulary alternative within the same contraceptive method (i.e., IUD copper, IUD with progestin, implantable rod, shot/injection, combined oral, extended/continuous use combined oral, progestin only oral, patch, vaginal ring, diaphragm with spermicide, sponge with spermicide, cervical vap with spermicide, male condom, female condom, spermicide alone, emergency use levonorgestrel, emergency use ulipristal)? ☐ Yes ☐ No
   If yes, please specify agent: _____
   If no, does the patient have an intolerance or hypersensitivity to a formulary alternative within the same contraceptive method? ☐ Yes ☐ No
   If yes, please explain: _____
   _____
   If no, is the contraceptive medically necessary? ☐ Yes ☐ No
   If yes, please explain: _____
   _____
3. Is the patient's sex female? ☐ Yes ☐ No
   If no, is the requested agent medically appropriate for the patient's sex? ☐ Yes ☐ No
   If yes, please explain: _____
   _____
4. Has the patient tried and failed at least TWO generic (MSC Y) formulary alternatives within the past 180 days? ☐ Yes ☐ No
   If yes, please specify agents: _____
   If no, are ALL available generic (MSC Y) alternatives contraindicated, likely to be less effective, or will cause an adverse reaction or other harm for the patient? ☐ Yes ☐ No
   If yes, please explain: _____
   _____

**Please continue to the next page.**

| Patient Name (First): | Last: | M: | DOB (mm/dd/yyyy): |
|---|---|---|---|
| | | | |

5. Has the patient tried and failed TWO brand name (MSC M or N) formulary (any formulary tier) alternatives (if applicable) for the diagnosis being treated with the requested drug? ..... ☐ Yes ☐ No

   If yes, please specify agents: _____

   If no, are ALL available brand name (MSC M, or N) formulary (any formulary tier) alternatives contraindicated, likely to be less effective, or will cause an adverse reaction or other harm for the patient? ..... ☐ Yes ☐ No

   If yes, please explain: _____

   _____

**Please fax or mail this form to:**

Horizon Blue Cross Blue Shield of New Jersey
c/o Prime Therapeutics LLC, Clinical Review Department
2900 Ames Crossing Road
Eagan, MN 55121

**TOLL FREE**

**Fax: 877.897.8808 Phone: 888.214.1784**

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