

# SPECIALTY DRUG REQUEST FORM

Once completed, please fax this form to **1-866-240-8123**.

To view our formularies on-line, please visit our Web site at the addresses listed above. Please use a separate form for each drug. Print, type or WRITE LEGIBLY and complete form in full. If approved, the payor will forward to the exclusive specialty vendor.

The exclusive specialty vendor can be reached at 888-347-3416.

**Note:** If you do not want this prescription to be sent to the exclusive specialty vendor, check here .

<b>PRESCRIPTION INFORMATION</b>			
<b>*** (When completed, this section represents a legal prescription) ***</b>			
Subscriber ID Number	Highmark Coverage <input type="checkbox"/> MA-PD <input type="checkbox"/> PDP	Group Number	
Patient Name	Phone Number	Date of Birth	
Patient Address	City	State	Zip Code
Drug name ( <u>only</u> specialty drugs)	Strength or Dose	Requested Quantity per Month	
Directions			
Refills	Date R <sub>x</sub> needed	Ship to (please check one) <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other _____	
Diagnosis			
Type of Transplant <input type="checkbox"/> Lung <input type="checkbox"/> Heart <input type="checkbox"/> Kidney <input type="checkbox"/> GVH <input type="checkbox"/> Other _____	Date of Most Recent Transplant	Most Recent Transplant Payer (check one) <input type="checkbox"/> Commercial <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Medicare FFS	
Name of Carrier who paid for Most Recent Transplant			
Physician Signature (required)	DEA	Date	
<b>ALTERNATIVES TRIED / USED BY PATIENT (IF APPLICABLE)</b>			
Drug Name	Strength	Documentation of Failure of Therapy	
Drug Name	Strength	Documentation of Failure of Therapy	
<b>MEDICAL RATIONALE / REASON FOR DRUG THERAPY / TREATMENT PLAN</b>			
<b>PHYSICIAN INFORMATION</b> (needed for mailing notification – please print legibly)			
Physician Name	NPI or Tax ID # (Required)	Phone	Fax
Physician Address	City	State	Zip Code
<b>MEDICARE</b>	<b>COMMERCIAL</b>	<b>REQUEST TYPE</b>	
<input type="checkbox"/> Tiering Exception <input type="checkbox"/> Non-Formulary <input type="checkbox"/> Prior Authorization	<input type="checkbox"/> Non-Formulary <input type="checkbox"/> Prior Authorization	<input type="checkbox"/> Standard Request <input type="checkbox"/> Expedited Request	<input type="checkbox"/> Peer to Peer <input type="checkbox"/> Expedited Appeal <input type="checkbox"/> Standard Appeal

Once a clinical decision has been made, a decision letter will be mailed to the patient and physician.  
For other helpful information, please visit the Web site at: <http://mydrug.formularies.com>

## INSTRUCTIONS FOR COMPLETING THE SPECIALTY DRUG REQUEST FORM

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.  
**NOTE:** The prescribing physician (PCP or Specialist) should, in most cases, complete the form.
3. Please provide the physician address as it is required for physician notification.
4. Fax the **COMPLETED** form to **1-866-240-8123**

Or mail to: **Medical Management & Policy**  
**120 Fifth Avenue, MC P4207**  
**Pittsburgh, PA 15222**

### CLINICAL MANAGEMENT PROCEDURES

In general, when requesting coverage for a medication, the following information identified below is required:

#### NON-FORMULARY

- Most products: documentation of a trial of at least two formulary products.

### SPECIALTY DRUGS REQUIRING PRIOR AUTHORIZATION

For specialty drugs within the therapeutic categories listed below, the diagnosis, applicable lab data, and additional information may be required. For detailed information regarding Pharmacy policies, please visit the Provider Resource Center via Navinet.

- **Anti-rheumatic medications**
- **Osteoporotic medications**
- **Growth hormones**
- **Interferons**
- **Miscellaneous**

Fertility agents, Gleevec, Raptiva, Nexavar, Revlimid, Thalomid, Revatio, Sprycel, Sutent, Tarceva, Tykerb, Zolanza, Kuvan

*Important Note: Please use the standard "Prescription Drug Medication Request Form" for all non-specialty drugs that require prior authorization.*

Please note that the drugs and therapeutic categories managed under our Prior Authorization and Managed Prescription Drug Coverage (MRXC) programs are subject to change based on the FDA approval of new drugs.

For other helpful information, please visit:

**<http://mydrug.formularies.com>**