Health First
Health Plans

REQUEST FOR COMMERCIAL PRESCRIPTION DRUG COVERAGE DECISION

This form may be sent to us by mail or fax:

Address:
6450 US Highway 1
Rockledge, FL 32955

Fax Number:
1.855.328.0061

You may also ask us for a coverage decision by phone (for Health Care Reform plans **only**) at 1.844.522.5282 or through our website at myHFHP.org.

Who May Make a Request: Your prescriber may ask us for a coverage decision on your behalf. If you want another individual (such as a family member or friend) to make a request for you, that individual must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name		Date of Birth
Enrollee's Address		
City	State	Zip Code
Phone	Enrollee's Member ID #	

Complete the following section ONLY if the person making this request is not the enrollee or prescriber:

Requestor's Name		
Requestor's Relationship to Enrollee		
Address		
City	State	Zip Code
Phone		

Representation documentation for requests made by someone other than enrollee or the enrollee's prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form or a written equivalent). For more information on appointing a representative, contact your plan.

Name of prescription drug you are requesting (if known, include strength and quantity requested per month):

Type of Coverage Decision Request

☐I need a drug that is not on the plan's list of covered drugs.

☐I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year.

☐I request prior authorization for the drug my prescriber has prescribed.

☐I request an exception to the requirement that I try another drug (step therapy) before I get the drug my prescriber prescribed.

☐I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my prescriber prescribed.

☐My drug plan charged me a higher copayment for a drug than it should have.

☐I want to be reimbursed for a covered prescription drug that I paid for out of pocket. (Please also complete and submit a COMMERCIAL Member Reimbursement Form)

NOTE: Requests that are subject to prior authorization (or any other utilization management requirement), may require supporting information. Your prescriber may use the attached "Supporting Information for an Exception Request or Prior Authorization" to support your request.

Additional information we should consider *(attach any supporting documents)*:

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Important Note: Expedited Decisions

If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting the standard timeframe could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescribers support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received.

☐CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS (if you have a supporting statement from your prescriber, attach it to this request).

Signature:	Date:

Supporting Information for an Exception Request or Prior Authorization

FORMULARY EXCEPTION requests may require supporting information and/or a prescribers supporting statement. PRIOR AUTHORIZATION requests may require supporting information.

☐**REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.**

Prescriber's Information		
Name		
Address		
City	State	Zip Code
Office Phone	Fax	
Prescriber's Signature		Date

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
Date Started: ☐ **NEW START**	Expected Length of Therapy:	Quantity per 30 days
Height/Weight:	Drug Allergies:	
DIAGNOSIS – Please list all diagnoses being treated with the requested drug and corresponding ICD-10 codes. **(**If the condition being treated with the requested drug is a symptom e.g. anorexia, weight loss, shortness of breath, chest pain, nausea, etc., provide the diagnosis causing the symptom(s) if known)		**ICD-10 Code(s)**
Other RELAVENT DIAGNOSES:		**ICD-10 Code(s)**

DRUG HISTORY: (for treatment of the condition(s) requiring the requested drug)

DRUGS TRIED (if quantity limit is an issue, list unit dose/total daily dose tried)	**DATES of Drug Trials**	**RESULTS of previous drug trials FAILURE vs INTOLERANCE (explain)**

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What is the enrollee's current drug regimen for the condition(s) requiring the requested drug?

DRUG SAFETY	
Any **FDA NOTED CONTRAINDICATIONS** to the requested drug?	☐ **YES** ☐ **NO**
Any concern for a **DRUG INTERACTION** with the addition of the requested drug to the enrollee's current drug regimen?	☐ **YES** ☐ **NO**
If the answer to either of the questions noted above is yes, please 1) explain issue, 2) discuss the benefits vs potential risks despite the noted concern, and 3) monitoring plan to ensure safety	
OPIOIDS – (please complete the following questions if the requested drug is an opioid)	
What is the daily cumulative Morphine Equivalent Dose **(MED)**?	☐ **mg/day**
Are you aware of other opioid prescribers for this enrollee? If so, please explain:	☐ **YES** ☐ **NO**
Is the stated daily MED dose noted medically necessary?	☐ **YES** ☐ **NO**
Would a lower total daily MED dose be insufficient to control the enrollee's pain?	☐ **YES** ☐ **NO**
RATIONALE FOR REQUEST	

☐**Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g. toxicity, allergy, or therapeutic failure** [Specify below if not already noted in the DRUG HISTORY section earlier on the form: (1) Drug(s) tried and results of drug trial(s) (2) if adverse outcome, list drug(s) and adverse outcome for each, (3) if therapeutic failure, list maximum dose and length of therapy for drug(s) trialed, (4) if contraindication(s), please list specific reason why preferred drug(s)/other formulary drug(s) are contraindicated]

☐**Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** A specific explanation of any anticipated significant adverse clinical outcome and why a significant adverse outcome would be expected is required – e.g. the condition has been difficult to control (many drugs tried, multiple drugs required to control condition), the patient had a significant adverse outcome when the condition was not controlled previously (e.g. hospitalization or frequent acute medical visits, heart attack, stroke, falls, significant limitation of functional status, undue pain and suffering),etc.

☐**Medical need for different dosage form and/or higher dosage** [Specify below: (1) Dosage form(s) and/or dosage(s) tried and outcome of drug trial(s); (2) explain medical reason (3) include why less frequent dosing with a higher strength is not an option – if a higher strength exists]

☐**Other** (explain below)

Required Explanation _____

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