Fax completed form to: 1-855-633-7673
Questions, please call: **1-855-703-4168**
24 hours a day 7 days a week
(TTY users call: 1-866-236-1069)

Affinity Health Plan

Request for Coverage of a Non-Formulary Drug

Patient Information	**Prescriber and Pharmacy Information**
Name ______	Name ______
Member ID ______	Specialty ______
Medicare ID ______	DEA ______
Date of Birth ______ Sex: M / F	NPI ______
Address ______	Address ______
City ______	City ______
State ______ ZIP ______	State ______ ZIP ______
Phone ______	Phone ______ Fax ______
Nursing Home Resident? YES / NO	Pharmacy name ______
Home care patient? YES / NO	NCPDP ______
	NPI ______
	Phone ______ Fax ______

All items below this line are for Physician Use Only

Information for Requested Drug

Drug Name: ______ Drug Requested is (circle one): Brand / Generic

Strength:______Dosage form:______Qty per 30 days:______Drug is (circle one): Newly prescribed/Refill
Directions:______ Diagnosis:______ ICD-9 Code:______

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review time frame will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Request for Coverage of a Non-Formulary Drug Criteria

Medical Justification: Please provide medical justification for the non-formulary drug exception request. Please address why all formulary alternatives on any tier of the formulary for treatment of the same condition would not be effective or would cause adverse effects. List previous drugs and doses attempted for this patient, condition and dates or approximate dates or duration of treatment (if known). Document adverse effects requiring discontinuation and/or reason for perceived ineffectiveness. Attach additional pages if necessary.

- ☐ If all formulary agents would not be effective, please specify prior treatment failures:______

- ☐ If all formulary agents would have adverse effects, please specify prior adverse effect history:______

- ☐ If patient preference for nonformulary drug, please provide your clinical rationale:______

- ☐ If no available formulary alternatives have been previously tried, please check this box.

I attest that the information provided on this form is true and accurate as of this date:

Prescriber's signature: ______ **Date:** ______