PRESCRIPTION DRUG MEDICATION REQUEST FORM FAX TO 1-866-240-8123

HIGHMARK.

HIGHMARK. HEALTH INSURANCE COMPANY

http://highmark.formularies.com https://hbs.highmarkprc.com/Pharmacy-Program-Formularies/Medicare-Formularies

To view our formularies on-line, please visit our Web site at the addresses listed above.
Fax each form separately. Please use a separate form for each drug.
Print, type or write legibly in blue or black ink. *See reverse side for additional details*

PATIENT INFORMATION

Subscriber ID Number	Highmark Coverage ❑ MA-PD ❑ PDP	Group Number

Patient Name	Patient Telephone Number	Date of Birth

Patient Address	City	State	Zip Code

CLINICAL / MEDICATION INFORMATION

Drug Name	Strength or Dose	Requested Quantity per Month

Diagnosis	Name of the Carrier who paid for Most Recent Transplant

Type of Transplant	Date of Most Recent Transplant	Most Recent Transplant Payer (check one)
❑ Lung ❑ Heart ❑ Kidney ❑ GVH ❑ Other _____		❑ Commercial ❑ Medicare Advantage ❑ Medicare FFS

Alternatives Tried / Used By Patient (if applicable)

Drug Name	Strength	Documentation of Failure of Therapy
Drug Name	Strength	Documentation of Failure of Therapy
Drug Name	Strength	Documentation of Failure of Therapy

Medical Rationale / Reason for Drug Therapy / Treatment Plan

PHYSICIAN INFORMATION (needed for mailing notification - please print legibly)

Physician Name	NPI or Tax ID # (Required)	Phone	Fax

Physician Address	City	State	Zip Code

Suite / Building	Physician Signature	Date

MEDICARE	COMMERCIAL	REQUEST TYPE	
❑ Tiering Exception	❑ Non-Formulary	❑ Standard Request	❑ Peer to Peer
❑ Non-Formulary	❑ Prior Authorization	❑ Expedited Request	❑ Expedited Appeal
❑ Prior Authorization			❑ 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 Highmark Web site at:
www.highmark.com

INSTRUCTIONS FOR COMPLETING THIS 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 and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **Clinical Services,**
   120 Fifth Avenue, MC P4207, Pittsburgh, PA 15222

CLINICAL SERVICES PROCEDURES

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

NON-FORMULARY

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

PRIOR AUTHORIZATION

Below is a list of common drugs and/or therapeutic categories that require prior authorization:

- Agents used for fibromyalgia (e.g. Cymbalta, Lyrica, Savella)
- Testosterone therapies
- Miscellaneous Items: contraceptives, Provigil, immediate release fentanyl products
  Contraceptives require a statement of medical necessity only
- Specialty drugs (e.g. Enbrel, Sutent, Tracleer, etc.)

MANAGED PRESCRIPTION DRUG COVERAGE (MRXC)

The MRXC program includes coverage for specific drug therapy categories with set thresholds or limits. The MRXC program uses specific criteria as set forth by Pharmacy and Therapeutics Committee to assess the information provided to support requests for additional quantities.

Below is a list of common drugs and/or therapeutic categories that are managed under our MRXC program:

- Medications used to treat Migraines (e.g. Amerge, Imitrex, Maxalt, etc.)
- Medications used to treat Onychomycosis (Lamisil and Sporanox)
- Leukotriene Modifiers (Singulair, Accolate, and Zyflo)
- Pain Management (OxyContin, Opana ER, etc.)

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

HIGHMARK MEDICARE-APPROVED FORMULARIES

Additional drugs and/or therapeutic categories that require prior authorization and the required information are listed below.

- Immunosuppressants: diagnosis and/or documentation of Medicare-approved organ transplant
- Methotrexate (oral): diagnosis
- Intravenous immune globulins: diagnosis and place of service

Categories of Drug Management is subject to change. For a comprehensive view of the Medicare Approved Formulary, please visit https://hbs.highmarkprc.com/Pharmacy-Program-Formularies/Medicare-Formularies

For a complete list of services requiring authorization, please access the Authorization Requirements page on the Highmark Provider Resource Center under Claims, Payment & Reimbursement > Procedure/Service Requiring Prior Authorization or by the following link: https://hbs.highmarkprc.com/Claims-Payment-Reimbursement/Procedure-Service-Requiring-Prior-Authorization