HIGHMARK DELAWARE

SPECIALTY DRUG REQUEST FORM

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

PRESCRIPTION INFORMATION

Subscriber ID Number		Highmark Coverage ❑ MA-PD ❑ PDP	Group Number
Patient Name		Phone Number	Date of Birth
Patient Address	City	State	Zip Code
Drug name (only specialty drugs)		Strength or Dose	Requested Quantity per Month
Directions			
Refills	Date R_x needed	Ship to (please check one) ❑ Physician's Office ❑ Patient's Home ❑ Other	
Diagnosis			
Type of Transplant ❑ Lung ❑ Heart ❑ Kidney ❑ GVH ❑ Other:		Date of Most Recent Transplant	Most Recent Transplant Payer (check one) ❑ Commercial ❑ Medicare Advantage ❑ Medicare FFS
Name of Carrier who paid for Most Recent Transplant		Is this medication for a chronic or long-term condition for which the prescription medication is necessary for the life of the patient? ❑ Yes ❑ No	
Physician Signature (required)		DEA	Date

ALTERNATIVES TRIED / USED BY PATIENT (IF APPLICABLE)

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

MEDICARE	COMMERCIAL	REQUEST TYPE	
❑ Tiering Exception ❑ Non-Formulary ❑ Prior Authorization	❑ Non-Formulary ❑ Prior Authorization	❑ Standard Request ❑ Expedited Request	❑ Peer to Peer ❑ Expedited Appeal ❑ 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 Delaware Web site at www.highmarkbcbsde.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

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 or visit **https://hdebcbs.highmarkprc.com/**

- **Anti-rheumatic medications**
- **Osteoporotic medications**
- **Growth hormones**
- **Interferons**
- **Miscellaneous**
  Fertility agents, Gleevec, Raptiva, Nexavar, Revlimid, Thalomid, Revatio, Sprycel, Sutent, Tarceva, Tykerb, Zolinza, 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.