HIGHMARK WEST VIRGINIA

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		
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 West Virginia web site at **http://mydrugformularies.com**. Once there, please click on the Highmark West Virginia logo for additional information.

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 completed form to: **PAPHM-043B**
   Clinical Services
   120 Fifth Avenue
   Pittsburgh, PA 15222

CLINICAL SERVICES PROCEDURES

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

SPECIALTY DRUGS REQUIRING PRIOR AUTHORIZATION

For the following specialty drugs and/or therapeutic categories, the diagnosis, applicable lab data, and involvement of specialists are required, plus additional information as specified:

Therapeutic Category
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 the MRXC programs are subject to change based on the FDA approval of new drugs.

For detailed information regarding Pharmacy policies please visit the Provider Resource Center via Navinet.

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://hwvbcbs.highmarkprc.com/Claims-Payment-Reimbursement/Outpatient-Procedures-Service-Requiring-Prior-Authorization