



833-273-2253  
219-810-6833 (Fax)

### Formulary Exception/Prior Authorization Request Form

| Patient Information                                                                                                                                                                                                 |            |                            |                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|----------------------------|--------------------------------|
| Patient Name:                                                                                                                                                                                                       |            | DOB:                       |                                |
| Patient ID#:                                                                                                                                                                                                        |            |                            |                                |
| Address:                                                                                                                                                                                                            |            |                            |                                |
| City:                                                                                                                                                                                                               | State:     | Zip:                       |                                |
| Phone #:                                                                                                                                                                                                            |            | Gender: M or F             |                                |
| Prescriber Information                                                                                                                                                                                              |            |                            |                                |
| Prescriber Name:                                                                                                                                                                                                    |            | NPI:                       |                                |
| Address:                                                                                                                                                                                                            |            |                            |                                |
| City:                                                                                                                                                                                                               | State:     | Zip:                       |                                |
| Contact Person:                                                                                                                                                                                                     |            | Fax #:                     |                                |
| Office Phone #:                                                                                                                                                                                                     |            | Ext:                       |                                |
| Drug Information                                                                                                                                                                                                    |            |                            |                                |
| Medication and Strength                                                                                                                                                                                             |            | Route of Administration    | Directions for Use (Frequency) |
| Quantity                                                                                                                                                                                                            | Day Supply | Expected Length of Therapy | ICD10 Code/Diagnosis           |
| <b>**PROVIDE ALL RELEVANT CLINICAL DOCUMENTATION AND LAB VALUES TO SUPPORT USE OF THIS MEDICATION.<br/>Solely providing demographic and drug information will not constitute a sufficient request for coverage.</b> |            |                            |                                |

**Expedited/Urgent Review Requested:** *By checking this box and signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.*



Continuation of Therapy:

- 1. Has the patient been receiving the requested drug within the last 120 days? Yes or No
2. How long has the patient been on the requested medication?
3. Has the patient had a positive response to treatment or had improvement in symptoms? Yes or No
4. Has the patient's need for continued therapy been assessed within the previous year? Yes or No

Is the requested product being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? Yes or No If yes, please indicate literature reference

Does the prescribed dose/quantity fall within the FDA-approved labeling or dosing guidelines found in the compendia of current literature? Yes or No

List ALL medications the patient has tried specific to the diagnosis and specify below:

- 1. Medication
Explanation for failure or contraindication
2. Medication
Explanation for failure or contraindication

\* ALL other medications tried, length/number of treatments, and reasons for failure:

Is the request for a patient with a highly sensitive condition (e.g., psychiatric condition, epilepsy, organ transplant) who is stable on the current drug(s) and who might be at high risk for a significant adverse event or harm with a medication change? If yes, specify anticipated significant adverse event:

Does the patient have a chronic condition confirmed by diagnostic testing? If yes, please provide diagnostic test and date:

Does the patient require a specific dosage form (e.g., suspension, solution, injection)? If yes, please provide dosage form and clinical explanation:

Does the patient have a clinical condition for which other formulary alternatives are not recommended or are contraindicated due to comorbidities or drug interactions based on published clinical literature? If so, please provide documentation including medication names and clinical reasons.



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**PRESCRIPTION BENEFIT PLAN MAY REQUEST ADDITIONAL INFORMATION OR CLARIFICATION, IF NEEDED,  
TO EVALUATE REQUESTS.**

**PLEASE FAX COMPLETED FORM TO 219-810-6833**

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by SevaRx, the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733.

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Confidentiality Notice:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, and distribution of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return fax) and arrange for the return or destruction of these documents.