PREMERA HMO

Pharmacy Prior Authorization and Exception Request

PO Box 327, MS XXX
Seattle, WA 98111-0327

Return the completed form by fax
- Attention: Pharmacy Services
- Fax number: 1-888-260-9836

Questions
- Phone number: 1-888-261-1756

A.	**Member information**		
1.	Name (First, M.I., and Last)		
	ID number	Date of birth (mm-dd-yyyy)	Phone number
	Physical address – No PO Box/PMB		
	City	State	ZIP code
B.	**Prescriber information**		
1.	Name (First, M.I., and Last)		
	Phone number	Fax number	
	Physical address – No PO Box/PMB		
	City	State	ZIP code
2.	NPI #	Date signed (mm-dd-yyyy)	
	Signature	Printed Name	

C. **Medication and Diagnosis Information**		
Medication (name and strength)	Diagnosis (ICD-10)	Quantity
New Script or Date Therapy Initiated	Expected Length of Therapy	Drug Allergies

D. Medical Necessity for Brand Name Contraceptives

☐ By checking this box you are certifying that a brand name contraceptive is medically necessary.

E. Request for Expedited Review (Determination within 24 hours)

☐ By checking this box and signing below, you are certifying that this is an expedited request due to an exigent circumstance and that the 72-hour standard review time may seriously jeopardize the life or health of the member or the member's ability to regain maximum function. The request will not be handled as an expedited request unless the box is checked and prescriber's signature is included.

Exigent circumstance: Applies to exception requests when a patient is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function

F. Type of Request (select all the apply)

☐ Member needs a drug that is not on the plan's list of covered drugs.

☐ Requesting an exception to the requirement that member tries another drug before member gets the drug prescribed.

☐ Requesting an exception to the plan's limit on the allowed amount (quantity limit) a member can receive.

☐ Requesting an exception to use a drug or biologic agent for an off-label indication.

NOTE: The prescriber MUST provide a statement supporting the exception request. Requests that are subject to prior authorization (or any other utilization management requirement) may require supporting information.

Chart notes are required

G. Clinical Rationale for the Exception Request (select all that apply)

☐ **Alternate drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure** [Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s)]

☐ **Patient is stable on current drug(s); high risk of significant adverse clinical outcome with medication change** [Specify below: Anticipated significant adverse clinical outcome]

☐ **Medical need for different and/or higher dosage** [Specify below: (1) Dosage form(s) and/or dosage(s) tried; (2) explain medical reason]

☐ **Off-label use is supported by medical compendia, scientific evidence, or approved via Emergency Use Authorization** (explain below)

☐ **Other** (explain below)

Required Explanation