Request an Exception

How to Request a Coverage Determination

Any of the following people can request a coverage determination:

- An enrollee,
- An enrollee's prescriber, or
- An enrollee's representative.

Requests need to be filed with your plan sponsor. You can ask for two kinds of determination:

- **Standard** - The plan sponsor must make its determination on a standard exception and notify the enrollee or the enrollee's designee, and the prescribing physician (or other prescriber) of its coverage determination no later than 72 hours following receipt of the request.

- **Expedited** - When there are exigent circumstances, an expedited exception may be requested. Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug. The plan sponsor must make its determination on an expedited exception and notify the enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) of its coverage determination no later than 24 hours following receipt of the request.

Either of these requests can be made orally or in writing. If you want to submit your request in writing, use the Model Coverage Determination Request Form. You can fill the form out and submit it electronically here: **Exception to Coverage**.

You may need to send attachments. If so, please fax or mail the form along with whatever you need to include.

If you need a hard copy of the form sent to you, call the number on the back of your prescription benefit card.

You may also ask us for a coverage determination orally by phone. To do this, call the number on the back of your prescription benefit card.

Who May Make a Request

Your doctor may ask us for a coverage determination for you. You can also have a different person, like a family member or friend, to make a request for you. That person must be identified as your representative. Call the number on the back of your prescription benefit card find out how to set this up.

The **Exception to Coverage** link above opens the form on the following page.

EXCEPTION TO COVERAGE

This form may be sent to us by mail or fax:

ADDRESS FAX	
P.O. Box 999 Appleton, WI 54912-0999 855-668-8553	
You may also ask us for an exception by phone at **866-333-2757**.	

PLEASE FILL OUT ALL FIELDS COMPLETELY			
Date		Prescriber Name	
Patient Name		Prescriber NPI	
Unique ID		Prescriber Phone	
Date of Birth		Prescriber Fax	

REQUESTED DRUG INFORMATION		DIAGNOSIS / REASON FOR USE / CLINICAL RATIONALE	
DRUG		**List Diagnosis**	**ICD9/ICD-10:**
STRENGTH			

REQUESTED DRUG INFORMATION		DIAGNOSIS / REASON FOR USE / CLINICAL RATIONALE
FREQUENCY		
QUANTITY		**Clinical Rationale:**
DURATION OF USE		

FORMULARY ALTERNATIVE(S)	MAX DOSE USED	DOSING FREQUENCY	USE START-END DATES	DESCRIBE SPECIFIC/ SIGNIFICANT SIDE EFFECTS AND/OR INEFFECTIVENESS

Processing TimeFrame

☐ **Standard Processing**

☐ **Urgent Processing**   (Urgent is defined as: There is an imminent and serious threat to your patient's health.To ensure immediate processing, please call 866-333-2757 for urgent requests.)

Has the patient already started on the requested medication ☐ Yes ☐ No

If yes, specify the duration of current therapy:

SUPPORTING INFORMATION FOR AN EXCEPTION REQUEST FOR PRIOR AUTHORIZATION

Please provide any additional clinical information required to establish medical necessity or

comments pertinent to this request for coverage:

Signature

Date

9/16/2016

9/16/2016 8:34:42 AM

Submit

I've also provided previously a copy of the PDF version of the form that we would provide to the caller if requested by phone.

The INSTRUCTIONS link above opens the information shown on the following page.

Instructions on How to Request an Exception

Use this form to ask for a drug to be covered. You can ask your doctor if you need help with this form.

1. Fill in your name, member ID and date of birth.
2. Fill in your doctor's name, phone number, and fax number.
3. Fill in the drug you are asking be covered.
   a. Enter the "Strength" of the drug, if you know. For example, 40mg.
   b. Enter how often you take the drug in the "Frequency" box. For example, once per day.
   c. Enter the number of pills you would need for a one month supply.
   d. Enter how long you expect to take the drug in the "Duration of Use" box. For example, long term or 3 months
4. Fill in the reasons you are using the drug in the "List Diagnosis" box.
5. Fill in the reason you need this drug in the "Clinical Rationale" box. For example, other drugs that are covered do not work for you.
6. Fill in other drugs you have tried that did not work in the "Formulary Alternatives" box.
   a. Enter the strength you took in the "Max Dose Use" box.
   b. Enter how often you took the drug in the "Dosing Frequency" box. For example, twice per day.
   c. Enter the date you started and stopped taking the drug.
   d. Include the reason it did not work. For example, Drug A made you sick. Drug B did not help your feel better.
7. Mark if this is urgent using the guideline on the form under "Processing Timeframe".
8. Mark if you are already using this drug. If you are using this drug, fill in how long you have been taking the drug.
9. Add other notes you want reviewed in the "Supporting Information" box.
10. Enter your name in the "Signature" box.
11. Click "Submit" to send this for review.
12. We will send a note with the decision to you and your doctor.