

Navitus Health Solutions PO BOX 999 Appleton, WI 54912-0999 Customer Care: 1-866-333-2757

## **Exception to Coverage Request**

Complete Legibly to Expedite Processing

Fax: 1-855-668-8551

COMPLETE REQUIRED CRITERIA AND FAX TO:		NAVITUS HEALTH SOLUTIONS 855-668-8551		
Date:		Prescriber Name:		
Patient Name:		Prescriber NPI:		
Unique ID:		Prescriber Phone:		
Date of Birth:		Prescriber Fax:		
REQUEST TYPE	Quantity Limit Increase <sup>1</sup>	<sup>1</sup> Gender-Spec	ific <sup>2</sup> High Dose <sup>3</sup>	
	☐ New Drug <sup>4</sup>		Not Covered <sup>5</sup>	

<sup>1</sup> Quantity Limit Increase: Dose prescribed exceeds allowed quantity limits. Indicate diagnosis/clinical rationale why the covered quantity and/or dosing are insufficient. See formularies at navitus.com for specific quantity limit restrictions.

<sup>2</sup> Gender-Specific Medications: Indicate diagnosis / clinical rationale for use.

- <sup>3</sup> High Dose Alert: Dose prescribed is flagged as >2.5 times the recommended maximum daily dose. Please provide monitoring criteria and/or clinical rationale for use of high dose.
- <sup>4</sup> New Drugs: Drug prescribed has not yet been reviewed by Navitus P&T Committee. For coverage consideration, all covered alternatives must be tried and failed or contraindicated. Complete the formulary alternatives table.
- <sup>5</sup> Not Covered Drugs: All formulary alternatives must be tried and failed or contraindicated. Complete the formulary alternatives table.

REQUESTED DRUG INFORMATION		INDICATION / REASON FOR USE / CLINICAL RATIONALE
DRUG/DOSE*		
INDICATION		
FREQUENCY		
QUANTITY		

\* If the drug requested is **BRAND** with an **A-RATED GENERIC**, an FDA MedWatch Form **must** be submitted. Access the form at <u>http://www.fda.gov/medwatch/getforms.htm</u> and attach a completed copy to request.

Formulary Alternative(s)	Max Dose Used	Dosing Frequency	Use Start End Dates	Describe Specific and Significant Side Effects and/or Ineffectiveness

\* If complex medical management exists, supply supporting documentation with this request.

If Approved, Coverage is granted for One Year

Prescriber Signature: \_\_\_\_\_

Date:

Access Formularies via our Provider Portal <u>www.navitus.com</u> > Providers> Prescribers Login