

Confidential

2181 E Aurora Rd Ste 201 Twinsburg OH 44087 Phone: 330-405-8080 Fax: 330-405-8081	Envision/Rx Options, Inc.
To:	From: Envision Rx Options Clinical Staff
Fax:	Pages: 3 inc cover
Phone:	Date:
Re:	Medication Exception Request for Elderplan Member

Dear Provider,

Your patient _____, has indicated that they need a medication exception for their drug.

Comments:

Please complete the attached form and fax back to **330-405-8081** attn: **Clinical Dept.**

Thank You,

The Clinical Staff
Envision Pharmaceutical Services

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FOR ENVISION INTERNAL USE ONLY – Date and Time Received Completed form from Doctor

ELDERPLAN / ENVISION Rx OPTIONS

Non-Formulary, Step Therapy, Quantity Limit Exception Request

IMPORTANT INFORMATION REQUIRED - FORM CANNOT BE PROCESSED WITHOUT REQUIRED SUPPORTING CLINICAL STATEMENT

Requests for non-formulary exceptions should only be made when the physician deems it medically necessary (i.e., patient has a documented allergy, adverse event or failed on the preferred formulary alternatives). A separate request must be completed for each patient.

Patient Information			Physician Information	
Patient Name			Name:	
Member ID#	Group#	Carrier	Office Phone:	
Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth:		Secure Office Fax Number:	
Office Contact Name:			NPI #	

Drug Name :				
Dose:		Directions:		Quantity:
Initial Therapy ?	Y N	Continuing Therapy ?	Y N	Has Dose Been Titrated? Y N
Anticipated Duration of Therapy:		Diagnosis/Indication(s):		

Please check all that apply:

EXCEPTION REQUEST FOR NON-FORMULARY DRUG

_____ None of the covered formulary drugs would be as effective as the requested drug for the treatment of this patient. Please provide details below by the asterisks**.

_____ The patient is intolerant to or has a documented allergy to all of the covered formulary drugs that may be effective for the treatment of the condition. Please provide details below by the asterisks**.

EXCEPTION REQUEST FOR STEP THERAPY

_____ The patient is intolerant to or has a documented allergy to all of the preferred formulary drugs under the step therapy requirement. Please provide details below by the asterisks**.

EXCEPTION REQUEST FOR QUANTITY LIMIT

_____ The patient has been effectively managed on the requested dose of this drug, with minimal adverse reactions. Please provide details below by the asterisks**.

**** Alternative formulary drug(s), dosage(s) and length of each therapy provided: _____**

****Supporting Clinical Statement** (such as lab values, contraindications, adverse outcomes, treatment failures, or any other additional clinical information to support non-formulary medication request):

Expedited Review (24 hours): The 72 hour standard review may seriously jeopardize the health or life of the member or the member's ability to regain maximum function (please explain above).

Fax to **1-330-405-8081** or mail to: Envision 2181 East Aurora Road Suite 201 Twinsburg, OH 44087
You will be notified within 72 hrs whether the request was approved. For inquiries, call 1-866-417-3064 (TTY 1-866-763-9630)

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA

**FOR ENVISION INTERNAL USE ONLY –
Sender Information:**

Date and Time of Communication to Pharmacy _____