

# Confidential

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

*Dear Provider,*

Your patient \_\_\_\_\_ has indicated that they need a tiering 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

## Drug Tiering Exception Request

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

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

Patient Information			Physician Information	
Patient Name			Name: <span style="float: right;">NPI#</span>	
Member ID#	Group#	Carrier	Address:	
Sex: M <input type="checkbox"/> F <input type="checkbox"/>		Date of Birth:	Office Phone Number	
Office Contact Name:			Secure Office Fax Number:	
<b>Drug Name :</b>				
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:**

\_\_\_\_\_ The 1<sup>st</sup> and/or 2<sup>nd</sup>-tier alternatives within the therapeutic class would not be as effective or have not been as effective as the requested drug for this patient (please explain below).

\_\_\_\_\_ The patient was intolerant of 1<sup>st</sup> and/or 2<sup>nd</sup>-tier alternatives within the therapeutic class (please provide details below).

\_\_\_\_\_ The patient has a documented allergy to the 1<sup>st</sup> and/or 2<sup>nd</sup>-tier alternatives within the therapeutic class (please explain below).

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

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**\*\*Supporting Clinical Statement** (such as contraindications, adverse outcomes, treatment failures, toxicities or any other additional clinical information to support medication request):

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**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** \_\_\_\_\_