

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:	Tier Exception Request for Elderplan Member

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: NPI#					
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:					
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:

_____ The 1st and/or 2nd-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 1st and/or 2nd-tier alternatives within the therapeutic class (please provide details below).

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

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

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

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Sender Information:

Date and Time of Communication to Pharmacy _____