

# Exception to Coverage Request

Processing Timeframe: Allow 72 hours for Exchange and Medicare Plans  
 and 2 business days for Commercial Plans and 24 hours for Expedited

**COMPLETE REQUIRED CRITERIA AND FORWARD TO:** WellFirst Health Pharmacy Services  
 1277 Deming Way  
 Madison, WI 53717  
 Fax: 608-252-0814

<b>Date:</b>		<b>Prescriber Name:</b>	
<b>Patient Name:</b>		<b>Prescriber NPI:</b>	
<b>Unique ID:</b>		<b>Prescriber Phone:</b>	
<b>Date of Birth:</b>		<b>Prescriber Fax:</b>	

<b>REQUEST TYPE:</b>	<input type="checkbox"/> Quantity Limit Increase <sup>1</sup>	<input type="checkbox"/> Gender-Specific <sup>2</sup>	<input type="checkbox"/> High Dose <sup>3</sup>
	<input type="checkbox"/> New Drug <sup>4</sup>		<input type="checkbox"/> 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
<b>DRUG*</b>		
<b>STRENGTH</b>		
<b>FREQUENCY</b>		
<b>QUANTITY</b>		

\* If the drug requested is BRAND with an A-RATED GENERIC, a United States Food and Drug Administration FDA MedWatch Form must be submitted. Access the form at <http://www.fda.gov/medwatch/getforms.htm> 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.

For questions, call Customer Service at 1-866-514-4194 or [www.wellfirstbenefits.com](http://www.wellfirstbenefits.com)

**If Approved, Coverage is Granted for One Year**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_