WellFirst Health™ 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		
Date:		**Prescriber Name:**	
Patient Name:		**Prescriber NPI:**	
Unique ID:		**Prescriber Phone:**	
Date of Birth:		**Prescriber Fax:**	

REQUEST TYPE:	☐ **Quantity Limit Increase**[1]	☐ **Gender-Specific**[2]	☐ **High Dose**[3]
	☐ **New Drug**[4]	☐ **Not Covered**[5]	

[1] **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.

[2] **Gender-Specific Medications:** Indicate diagnosis / clinical rationale for use.

[3] **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.

[4] **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.

[5] **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*		
STRENGTH		
FREQUENCY		
QUANTITY		

* 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

If Approved, Coverage is Granted for One Year

Prescriber Signature: _____ **Date:** _____

Complete Legibly to Expedite Processing