



Medicare Step B Therapy Exception to Coverage Request

**Allow 72 hours for Processing Complete
Legibly to Expedite Processing**

COMPLETE REQUIRED CRITERIA AND FORWARD TO:

Navitus Health Solutions
5 Innovations Court, Suite B
Appleton, WI 54914
Fax: 855-668-8551 (toll free) 920-735-5350 (Local)

Date:		Prescriber Name:	
Patient Name:		Prescriber NPI:	
Unique ID:		Prescriber Phone:	
Date of Birth:		Prescriber Fax:	

REQUEST TYPE:	<input type="checkbox"/> Non-Preferred Drugs¹	<input type="checkbox"/> Part D Drugs First²
----------------------	---	--

¹ **Non-Preferred Drugs:** All formulary preferred must have been tried within the last 365 days and treatment failed or is contraindicated. Complete the formulary alternatives table and indicate clinical rationale.

² **Part D Drugs First:** Prior use of **oral** Part D medications before Part B medication is started. Indicate usage of all formulary preferred and clinical rationale and dates of treatment failure or contraindication.

REQUESTED DRUG INFORMATION	INDICATION / REASON FOR USE / CLINICAL RATIONALE		
DRUG*			
STRENGTH			
FREQUENCY			
QUANTITY			

Please list ALL Preferred Agents that MEMBER has tried within the LAST 365 DAYS:

Preferred Agents	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.

If Approved, Coverage is Granted for One Year

Prescriber Signature: _____ **Date:** _____