12/3/2014

Prior Authorization Form

OSCAR HEALTHCARE NY EXCHANGE

Non-Formulary Marketplace Exception (HMF)

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-855-245-2134**.

Please contact CVS/Caremark at **1-855-582-2022** with questions regarding the prior authorization process.

When conditions are met, we will authorize the coverage of Non-Formulary Marketplace Exception (HMF).

Drug Name (select from list of drugs shown)

Other, Please specify

Quantity _____ **Frequency** _____ **Strength** _____

Route of Administration _____ **Expected Length of Therapy** _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested drug being used for an FDA-Approved indication OR an indication supported in the compendia of current literature (examples: AFHS, Micromedex, current accepted guidelines)? Y N

2. Is the request for a formulary medication for more than the initial quantity limit? Y N

   [If the answer to this question is yes, then skip to question 6.]

3. Is the patient unable to take the preferred formulary alternatives for the given diagnosis due to inadequate treatment response, intolerance, or contraindication? (Requirement: 3 in a class with 3 or more alternatives, 2 in a class with 2 alternatives, or 1 in a class with only 1 alternative). If yes, documentation is required for approval. Provide documentation including name of medication(s) tried, dates of trial(s) and reason for treatment failure(s), intolerance and/or contraindication whichever are applicable. Y N

[If the answer to this question is yes, then skip to question 6.]

4. Does the patient have a clinical condition for which there is no formulary alternative or the listed formulary alternatives are not recommended based on published guidelines or clinical literature? If yes, documentation is required for approval. Provide documentation including the clinical condition. Y N

[If the answer to this question is yes, then skip to question 6.]

5. Does the patient require use of a specific dosage form that is not available in the formulary alternatives (examples: suspension, solution, injection)? Y N

6. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Micromedex, current accepted guidelines)? If yes, documentation is required for approval. Provide documentation including name of medication, quantity, strength, directions, and duration requested. Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date