HIGHMARK BLUE SHIELD

HIGHMARK BlueRx
A Medicare Prescription Drug Plan from Highmark Senior Resources Inc.

medmark SPECIALTY PHARMACY SOLUTIONS

http://highmark.formularies.com http://highmark.medicare-approvedformularies.com

Specialty Drug Request Form

Once completed, please fax this form to **1-866-240-8123.**
To view our formularies on-line, please visit our Web site at the addresses listed above.
Please use a separate form for each drug. Print, type or WRITE LEGIBLY and complete form in full.
If approved, Highmark will forward to Medmark, Inc. Medmark can be reached at 888-347-3416.
Note: If you **do not** want this prescription to be sent to Medmark, check here ❑.

PRESCRIPTION INFORMATION

****** (When completed, this section represents a legal prescription) ******

Subscriber ID Number		**Group Number**	
Patient Name		**Phone Number**	**Date of Birth**
Patient Address	**City**	**State**	**Zip Code**
Drug name (only specialty drugs)		**Strength**	**Quantity**
Directions		**Refills**	**Diagnosis**
Date R_x needed		**Ship to (please check one)** ❑ Physician's Office ❑ Patient's Home ❑ Other _____	
Physician Signature (required)		**DEA**	**Date**

Alternatives Tried / Used by Patient (if applicable)

Drug Name	**Strength**	**Documentation of Failure of Therapy**
Drug Name	**Strength**	**Documentation of Failure of Therapy**

Medical Rationale / Reason for Drug Therapy / Treatment Plan

PHYSICIAN INFORMATION (needed for mailing notification – please print legibly)

Physician Name		**Phone**	**Fax**
Physician Address	**City**	**State**	**Zip Code**

FOR INTERNAL REVIEW

❑ **Approved** ❑ **Denied** ❑ **Not Applicable** ❑ **Benefit Denial**

Reason Code	**Decision Date**	**Reviewer's Initials**

Notification of Decision Given: ❑

Internal Rep: _____

Contact Name: _____

Date: **Time:** **am / pm**

Once a clinical decision has been made, a decision letter will be mailed to the patient and physician.
For other helpful information, please visit the Highmark Web site at: **www.highmark.com**

Instructions for Completing the Specialty Drug Request Form

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.
   NOTE: The prescribing physician (PCP or Specialist) should, in most cases, complete the form.
3. Please provide the physician address as it is required for physician notification.
4. Fax the **COMPLETED** form to **1-866-240-8123**

   Or mail to: **Medical & Pharmacy Affairs**
   P.O. Box 279
   Pittsburgh, PA 15230

Clinical Management Procedures

In general, when requesting coverage for a medication, the following information identified below is required:

Non-Formulary

- Most products: documentation of a trial of at least two formulary products.

Specialty Drugs Requiring Prior Authorization

For the following specialty drugs and/or therapeutic categories, the diagnosis, applicable lab data, and involvement of specialists are required, plus additional information as specified:

Anti-rheumatic drugs (Enbrel, Humira, Kineret)
Forteo: at least two other osteoporotic therapies and risk for fractures (e.g., T-score)
Growth Hormone: bone age, growth chart, and stim tests
Miscellaneous Items: Actimmune, Avonex, Betaseron, Fertility Agents, Gleevec, Infergen, Intron A, Iressa, PEG Intron, Pegasys, Raptiva, Rebif, Roferon-A

Important Note: Please use the standard "Prescription Drug Medication Request Form" for all non-specialty drugs that require prior authorization.

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www.highmark.com