01/15/2013

HEALTHFIRST NJ FAMILY CARE (MEDICAID)

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Global Prescription Exceptions (Medicaid)

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 **1-866-848-5088**.
Please contact CVS/Caremark at **1-877-423-7643** with questions regarding the healthfirst nj family care (medicaid) process.
When conditions are met, we will authorize the coverage of Global Prescription Exceptions (Medicaid).

Drug Name (select from list of drugs shown)

Other, please specify

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:** _____

Please circle the appropriate answer for each question.

1. Is the requested drug being used for an FDA-Approved indication? Y N
   [If the answer to this question is yes, then skip to question 3.]
2. Is the requested drug being used for an indication that is supported by information from the appropriate compendia of current literature (e.g., AHFS, Micromedex, current accepted guidelines, etc.)? Y N
3. Is the request for a formulary medication, and the request is for more than the initial quantity limit? Y N
   [If the answer to this question is yes, then skip to question 9.]
4. Has the patient demonstrated a failure of or intolerance to a majority (not more than 3) of the preferred formulary/PDL alternatives for the given diagnosis? If so, please provide documentation including medication(s) tried, dates of trial(s) and reason for treatment failure(s) Y N _____
   [If the answer to this question is yes, then skip to question 9.]
5. Does the patient have a contraindication to the listed formulary alternatives? If so, please provide documentation Y N _____
   [If the answer to this question is yes, then skip to question 9.]
6. Has the patient had an adverse reaction to OR would be reasonably expected to have an adverse reaction to the listed Y N

	formulary alternatives? If so, please provide documentation [If the answer to this question is yes, then skip to question 9.]		
7.	Does the patient have a clinical condition for which the listed formulary alternatives are not recommended based on published guidelines or clinical literature? If so, please provide documentation [If the answer to this question is yes, then skip to question 9.]	Y N	
8.	Does the patient require use of a specific dosage form (e.g., suspension, solution, injection) that is not available as the formulary alternatives?	Y N	
9.	Is the drug being prescribed within the manufacturer's published dosing guidelines or falls within dosing guidelines found in the compendia of current literature (e.g., package insert, AHFS, Micromedex, current accepted guidelines, etc.)? Please document quantity, strength, directions and duration requested.	Y N	
10.	Is the drug being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program?	Y N	

Comments: _____

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

_____

Prescriber (Or Authorized) Signature and Date