One Monarch Place
Suite 1500
Springfield, MA 01144-1500
www.hne.com
Pharmacy Department Fax: 413-233-2777

Medication Request Form

Instructions:
This form is to be used by participating physicians and pharmacy providers to obtain coverage for the Exceptions listed below, along with Medicare Part B Exceptions. Complete this form and fax to Health New England Pharmacy Services Department at **413-233-2777**. For Medicare Part B Requests please refer to the section below. If you have any questions regarding this process, contact Health New England Member Services Department at (800) 310-2835. For any Medicare Part D requests please visit www.hne.com/medicare for further information.

To Prevent any Delays in ProcessingPlease complete all Patient Information and Drug Information

PATIENT INFORMATION (ALL REQUIRED):	PRESCRIBER'S INFORMATION	
PATIENT NAME:	PRESCRIBER'S PRINTED NAME:	SPECIALTY:
PATIENT HNE ID#:	NPI #:	HNE PROVIDER#:
PATIENT DATE OF BIRTH:	OFFICE PHONE #: ( ) -	OFFICE FAX #: ( ) -
ALLERGIES:	OFFICE CONTACT NAME:	
DIAGNOSIS:	PHYSICIAN SIGNATURE:	DATE:
CO-MORBID CONDITIONS WHICH MAY BE RELEVANT:		

DRUG INFORMATION:		
REQUESTED DRUG NAME:	PAST FAILURES/DATES TRIED:	TYPE OF EXCEPTION (CHECK ALL THAT APPLY): *Please allow 3-15 days for processing ☐ QUANTITY LIMITATION Reasons for exceeding limit:
DOSE/STRENGTH/FORM (please be specific):	REASON FOR DISCONTINUATION (attach additional information when applicable):	
FREQUENCY PER DAY/QUANTITY PER MONTH:		☐ STEP THERAPY ☐ Patient has filled a prescription and tried a step 1 (generic) drug in the previous 180 days. THIS EXCLUDES THE USE OF SAMPLES
DURATION OF REQUESTED TREATMENT:		☐ MULTISOURCE BRAND Documented allergic reaction to generic formulation (please attach form)
SIGNIFICANT LAB VALUES:		☐ NEW-TO-MARKET *For Commercial HNE Members an approval will result in a copay of $50 or 50% of the price of the drug whichever is greater.

THIS SECTION APPLIES ONLY TO HNE MEDICARE ADVANTAGE MEMBERS
Please fax Medicare Part B Prior Authorization requests to: HNE Health Services Department 413-233-2700

REQUESTED DRUG NAME (INCLUDE STRENGTH):	DIRECTIONS:	OTHER PERTINENT INFORMATION (attach additional information when applicable):
HOW WILL PROVIDER BE ADMINISTRATING (BUY AND BILL OR PHARMACY PRESCRIPTION):		
DIAGNOSIS OR CONCURRENT DISEASE STATES:		
PLEASE LIST ANY CONTRAINDICATIONS TO FORMULARY, ALTERNATIVE OR GENERIC MEDICATIONS:		

© 2011 Health New England, Inc.