COVERAGE DETERMINATION REQUEST FORM

EOC ID:

WMH_NON-FORMULARY EXCEPTION

Phone: Fax back to: 1-866-678-8301

WithMe Health™ manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

☐ Standard ☐ Expedited / Urgent

Please attach any pertinent medical history or information for this patient that may be used for exception review. Please review and answer the following questions and sign.

Patient Name:	Prescriber Name:

Member/Subscriber Number:	Fax:	Phone:
Date Of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Medication Request Information

1. Please indicate the name and strength of the requested medication *

2. Please indicate the quantity, day supply, and frequency of use for requested medication

3. Is this for Initial or Continuation of Therapy?

- ☐ Initial Therapy
- ☐ Continuation of Therapy

If request is for continuation, please provide initial start date of medication: _____

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4. Please list the diagnosis being treated with the requested drug.

**Note: When requested medication is for off-label use, including but not limited to indication, age, or dosage, please submit two (2) evidence-based clinical trials or guidelines as supporting evidence of safety and efficacy for use of the medication for this diagnosis (These documents are in addition to clinical documentation to support patient diagnosis.)

5. Please provide all ICD-10 Code(s) relevant to the medication request

Patient Medication History

6. Has the patient tried and failed at least two (2) formulary alternatives, in at least 2 different classifications when available, of at least 90 days in duration for each alternative?

- ☐ Yes
- ☐ No
- ☐ N/A

7. Please indicate all formulary alternatives that have been tried/failed, the duration of therapy, and the timeframe of the failure pertaining to this diagnosis. If the answer to previous question is not applicable (N/A), please provide reason below.

8. Does the patient have a contraindication or intolerance to any or ALL formulary alternative medications based on the member's diagnosis, medical conditions, or other medication therapies?

- ☐ Yes
- ☐ No

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9. If all formulary alternatives are contraindicated or the patient has a documented intolerance, please provide the name of the medication(s), the specific reason why each alternative is contraindicated, and the adverse outcome resulting from the use of each alternative.

Medication Name/Strength	Contraindication/Intolerance	Adverse Outcome/Reaction