Print Form

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Non-Formulary Drug Coverage Request Form

This form is to be used for requesting a drug formulary exception for medications that are not on UHA's formulary list. It allows the member, the member's designee, or the member's prescribing physician (or other prescriber) permission to request and gain access to clinically appropriate drugs. All pages must be completed with accurate information. Your prescribing physician must also complete page 2 and attach the necessary clinical notes.

Do not use *this form for the purpose of requesting changes in coverage for formulary drugs which are covered by the plan, copay overrides, or tier determination.*

Who May Make a Request?

The member, the member's prescribing physician, or another individual (family member or friend) may complete this request. If anyone other than the member is completing this form, complete the *HIPAA Authorization for Release of Information* or a written statement giving permission and attach it to this request. For more information regarding HIPAA, contact our Customer Services Department at 808-532-4000.

1. Member's Information (Required):

Member's Name	Date of Birth
Member's Address	
Phone Day: Evening:	Member ID #

2. To be completed by the member's designee and or representative ONLY (not the member or prescriber):

Representative's Name	Date of Birth
Representative's Relationship to the Member	Phone Day: Evening:
Address	Signature

3. Drug Information (Required):

Prescription drug you are requesting (if known, include strength and quantity requested per month):		
Drug Name		
Strength	Quantity	Duration

Please check off the reason for completing this request?

☐ I need a drug that is **not** on your Plan's list of covered drugs (formulary exception).

☐ I have been using a drug that was previously on your Plan's formulary drug list, but is being removed or was removed from the list.

☐ I am switching from another insurance company who covered this medication(s).

Additional information we should consider *(attach any supporting documents)*:

_____

_____

I acknowledge that the above information is true and accurate. I, or my representative acting on my behalf, attest that the requested information above meets criteria for this exception.

Member's Signature: **Date:**

_____

To be completed by your Primary Care Physician or Prescribing Doctor
Please attach the necessary clinical notes

Prescriber's Information			
Name		Specialty	
Address	City	State	Zip Code
Office Phone	Office Fax	Contact Person	
Prescriber's Signature			Date

Diagnosis and Medical Information		
Medication	Strength & Route of Administration	Frequency
New Prescription OR Date Therapy Initiated	Expected Length of Therapy	Quantity
Height/Weight	Drug Allergies	Diagnosis

Review Timeframe & Rationale for Request:

☐ **REQUEST FOR STANDARD REVIEW:** By checking this box and signing below, I certify that applying the **72 hour** standard review timeframe is sufficient.

☐ **REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that the member meets exigent circumstances. Therefore we are requesting the **24 hour** expedited timeframe.

> ***Exigent circumstances** exist when a member is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function, or when a member is undergoing a current course of treatment using a non-formulary drug.*

☐ **Alternate formulary drug(s) contraindicated or previously tried, but with adverse outcome, e.g., toxicity, allergy, or therapeutic failure** [Specify below: (1) Drug(s) contraindicated or tried; (2) adverse outcome for each; (3) if therapeutic failure, length of therapy on each drug(s)]

☐ **Patient is stable on current non-formulary drug(s); high risk of significant adverse clinical outcome with medication change** [Specify below: Anticipated significant adverse clinical outcome]

☐ **Other** (explain below)

_____
_____
_____
_____

This form may be sent to us by mail or fax:

UHA Health Insurance
Attn: Health Care Services Department
700 Bishop St., Suite 300
Honolulu, HI 96813

Fax: 1-866-572-4384