

## Healthcare Reform Copay Waiver Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

Clinical Information <small>(required)</small>
<p><b>What is the patient's diagnosis for the medication being requested?</b>                      ICD-10 Code(s): _____</p>
<p><b>For contraceptives, ONLY the following section needs to be answered:</b>                      Is the patient using the prescribed drug for contraception? <input type="checkbox"/> Yes <input type="checkbox"/> No                      Is the requested product medically necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No                      If yes, please specify: _____</p>
<p><b>For all other products, please answer the following:</b>                      What medication(s) has the patient tried and had an inadequate response to? (Please specify <u>ALL</u> medication(s)/strengths tried, length of trial, and reason for discontinuation of each medication)</p>
<p><b>For all other products, please answer the following:</b>                      What medication(s) does the patient have a contraindication or intolerance to? (Please specify <u>ALL</u> medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)</p>
<p><b>For all other products, please answer the following:</b>                      Are there any supporting labs or test results? (Please specify)</p>
<p><b>For all other products, please answer the following:</b>  <b>Quantity limit requests:</b>                      What is the quantity requested per DAY? _____  <b>What is the reason for exceeding the plan limitations?</b>  <input type="checkbox"/> Titration or loading dose purposes  <input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)  <input type="checkbox"/> Requested strength/dose is not commercially available  <input type="checkbox"/> Patient requires a greater quantity for the treatment of a larger surface area <b>[Topical applications only]</b>  <input type="checkbox"/> Other: _____</p>

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

Please note: This request may be denied unless all required information is received.  
 For urgent or expedited requests please call 1-800-711-4555.  
 This form may be used for non-urgent requests and faxed to 1-844-403-1029.