

Request for Prior Authorization Approval for Coverage of an Excluded/Limited Drug
MEDICAL NECESSITY REVIEW

EMPLOYEE SECTION

To request coverage for an excluded/limited prescription drug or a medication not covered under the formulary, this form must be completed by the Employee and Treating Physician. Approval is required prior to Plan payment and is based on medical necessity and other plan design features. The Plan will notify the employee upon completion of the review and any limitations that may apply, including Site of Care. All approvals and reviews are subject to Plan changes and are limited to a maximum of one year. Upon approval, member may be subjected to co-payment: \$20 plus 50% of AWP to a maximum of \$200.

Employee Name _____ Phone Number _____
Employee SS # _____ Work Phone/Ext _____
Office/Dept. _____ Group No. _____ Patient at Wood County Health Center

Employee's Signature (Retain a copy for your records) _____ Date _____

PHYSICIAN SECTION

Patient Name _____ Patient Birth Date _____
Patient's Relationship to Subscriber _____
Name of drug requested for approval: _____
Dosage _____ **Quantity** _____ **Days Supply** _____
Prescription Duration: _____
Identify if utilizing a drug discount program/coupon for this medication: Yes No
Medical Condition _____
Medical History _____
Type of Treatment _____
Formulary Alternatives Tried _____
Other Medications/Therapies tried and reason(s) for failure and/or any other information in addition to the office notes/history. Include any previous or current therapy related to the diagnosis, using drug names and dates.

Must provide all office notes/history to assist with medical necessity determination including compliance with treatment plan. Include length of trial and/or if samples were given. Incomplete data results in denial of request.
Treating Physician Name _____
Physician Phone _____ Physician Fax _____

Treating Physician's Signature _____ Date _____

PLEASE PRINT OR TYPE

Send completed form via secure e-mail to benefitclerk@woodcountyoohio.gov or confidential fax to 419-353-7429.

FOR PLAN USE ONLY

- Additional information required. Information requested _____
- Not Approved Not Approved: Incomplete Form/Supporting Documentation
- Approved from _____ to _____ (Not to exceed one year.)
Co-Payment: \$20 plus 50% of AWP to a maximum of \$200. Contact the Plan to learn more about lowering this co-payment.
 - Health Third Party Administrator: Pay for administration cost only.**
 - Purchase is permitted at lowest price point pharmacy: _____
 - Prescription is over \$1,000. Estimated cost prior to coverage _____
 - Maximum number of prescription fills per approved timeframe _____

Notified/Copied to employee on _____ Program Administrator _____ Date _____