



http://highmark.formularies.com



http://highmark.medicare-approvedformularies.com



# Specialty Drug Request Form

Once completed, please fax this form to **1-866-240-8123**.

To view our formularies on-line, please visit our Web site at the addresses listed above. Please use a separate form for each drug. Print, type or WRITE LEGIBLY and complete form in full. If approved, Highmark will forward to Medmark, Inc. Medmark can be reached at 888-347-3416.

**Note:** If you **do not** want this prescription to be sent to Medmark, check here .

PRESCRIPTION INFORMATION			
<i>*** (When completed, this section represents a legal prescription) ***</i>			
Subscriber ID Number		Group Number	
Patient Name		Phone Number	Date of Birth
Patient Address		City	State Zip Code
Drug name (only specialty drugs)		Strength	Quantity
Directions		Refills	Diagnosis
Date Rx needed		Ship to (please check one) <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other	
Physician Signature (required)		DEA	Date
Alternatives Tried / Used by Patient (if applicable)			
Drug Name	Strength	Documentation of Failure of Therapy	
Drug Name	Strength	Documentation of Failure of Therapy	
Medical Rationale / Reason for Drug Therapy / Treatment Plan			
PHYSICIAN INFORMATION (needed for mailing notification – please print legibly)			
Physician Name		Phone	Fax
Physician Address		City	State Zip Code
FOR INTERNAL REVIEW			
<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Not Applicable <input type="checkbox"/> Benefit Denial		Notification of Decision Given: <input type="checkbox"/>	
Reason Code	Decision Date	Reviewer's Initials	Internal Rep: _____
			Contact Name: _____
			Date: _____ Time: _____ am / pm

Once a clinical decision has been made, a decision letter will be mailed to the patient and physician. For other helpful information, please visit the Highmark Web site at: [www.highmark.com](http://www.highmark.com)

# Instructions for Completing the Specialty Drug Request Form

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.  
**NOTE:** The prescribing physician (PCP or Specialist) should, in most cases, complete the form.
3. Please provide the physician address as it is required for physician notification.
4. Fax the **COMPLETED** form to **1-866-240-8123**  
Or mail to: **Medical & Pharmacy Affairs**  
**P.O. Box 279**  
**Pittsburgh, PA 15230**

## Clinical Management Procedures

In general, when requesting coverage for a medication, the following information identified below is required:

### **Non-Formulary**

- Most products: documentation of a trial of at least two formulary products.

### **Specialty Drugs Requiring Prior Authorization**

For the following specialty drugs and/or therapeutic categories, the diagnosis, applicable lab data, and involvement of specialists are required, plus additional information as specified:

Anti-rheumatic drugs (Enbrel, Humira, Kineret)
Forteo: at least two other osteoporotic therapies and risk for fractures (e.g., T-score)
Growth Hormone: bone age, growth chart, and stim tests
<b>Miscellaneous Items:</b> Actimmune, Avonex, Betaseron, Fertility Agents, Gleevec, Infergen, Intron A, Iressa, PEG Intron, Pegasys, Raptiva, Rebif, Roferon-A

***Important Note: Please use the standard "Prescription Drug Medication Request Form" for all non-specialty drugs that require prior authorization.***

For other helpful information, please visit the Highmark Web site at:  
**[www.highmark.com](http://www.highmark.com)**