WellFirst Health®
provided by SSM Health Plan

# Exception to Coverage Request

**Processing Timeframe: Allow 72 hours for Exchange and Medicare Plans and 2 business days for Commercial Plans and 24 hours for Expedited**

| **COMPLETE REQUIRED CRITERIA AND FORWARD TO:** | Navitus Health Solutions<br>5 Innovations Court, Suite B<br>Appleton, WI 54914<br>Fax: 855-668-8551 (toll free) 920-735-5350 (Local) | | |
|---|---|---|---|
| **Date:** | | **Prescriber Name:** | |
| **Patient Name:** | | **Prescriber NPI:** | |
| **Unique ID:** | | **Prescriber Phone:** | |
| **Date of Birth:** | | **Prescriber Fax:** | |

| **REQUEST TYPE:** | ☐ **Quantity Limit Increase**[1] | ☐ **Gender-Specific**[2] | ☐ **High Dose**[3] |
|---|---|---|---|
| | ☐ **New Drug**[4] | ☐ **Not Covered**[5] | |

[1] **Quantity Limit Increase:** Dose prescribed exceeds allowed quantity limits. Indicate diagnosis/clinical rationale why the covered quantity and/or dosing are insufficient. See formularies at navitus.com for specific quantity limit restrictions.

[2] **Gender-Specific Medications:** Indicate diagnosis / clinical rationale for use.

[3] **High Dose Alert:** Dose prescribed is flagged as >2.5 times the recommended maximum daily dose. Please provide monitoring criteria and/or clinical rationale for use of high dose.

[4] **New Drugs:** Drug prescribed has not yet been reviewed by Navitus P&T Committee. For coverage consideration, all covered alternatives must be tried and failed or contraindicated. Complete the formulary alternatives table.

[5] **Not Covered Drugs:** All formulary alternatives must be tried and failed or contraindicated. Complete the formulary alternatives table.

| **REQUESTED DRUG INFORMATION** | | **INDICATION / REASON FOR USE / CLINICAL RATIONALE** |
|---|---|---|
| **DRUG*** | | |
| **STRENGTH** | | |
| **FREQUENCY** | | |
| **QUANTITY** | | |

* If the drug requested is BRAND with an A-RATED GENERIC, a United States Food and Drug Administration FDA MedWatch Form must be submitted. Access the form at http://www.fda.gov/medwatch/getforms.htm and attach a completed copy to request.

| Formulary Alternative(S) | Max Dose Used | Dosing Frequency | Use Start-End Dates | Describe Specific And Significant Side Effects and/or Ineffectiveness |
|---|---|---|---|---|
| | | | | |
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** If complex medical management exists, supply supporting documentation with this request.
For questions, call Customer Service at 1-866-514-4194 or www.wellfirstbenefits.com
**If Approved, Coverage is Granted for One Year**

**Prescriber Signature:** _____ **Date:** _____

**Complete Legibly to Expedite Processing**