Navitus Health Solutions
PO BOX 999
Appleton, WI 54912-0999
Customer Care: 1-855-673-6504

Fax: 1-855-668-8551

Exception to Coverage Request

Complete Legibly to Expedite Processing

COMPLETE REQUIRED CRITERIA AND FAX TO:		NAVITUS HEALTH SOLUTIONS **855-668-8551**	
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 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,** an 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

** If complex medical management exists, supply supporting documentation with this request.

If Approved, Coverage is Granted for One Year

Prescriber Signature: _____ **Date:** _____