



Medical Necessity Review Form for Non-Formulary Medication

An Independent Licensee of the Blue Cross and Blue Shield Association

Fax Completed Forms to Pharmacy Operations: 515-376-9008

PATIENT INFORMATION		PRESCRIBER INFORMATION		
PATIENT NAME:		PRESCRIBER NAME:		
Member Wellmark ID:		Prescriber NPI:		
Address:		Address:		
City:	State:	City:	State:	ZIP Code:
ZIP Code:	Date of Birth: / /	Office Phone #: ()	Fax #: ()	
Coverage Type: <input type="checkbox"/> Hawki <input type="checkbox"/> Blue Rx Preferred <input type="checkbox"/> SD Member <input type="checkbox"/> IA Member		Submission Date ____/____/____		

NON-FORMULARY MEDICATION INFORMATION

Medication:	Strength:	Quantity:	ICD-9 Code:
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Prescriber Signature: _____

If a non-formulary medication is approved it will process at the members highest cost share.

RATIONALE FOR EXCEPTION

- Attest that ALL formulary drug(s) cause an adverse reaction in the patient. **Specify below**
- Attest that ALL formulary drug(s) are contraindicated for the patient. **Specify below**
- Attest that the patient has tried ALL formulary alternatives for the diagnosis being treated with requested medicine and was unsuccessful. **Specify below**

If provider attests to any of the above questions the following question MUST also be answered

- Demonstrate in writing to Wellmark that the provider has considered ALL equivalent drugs on the formulary and has determined that the drug prescribed will best treat the patient's condition. **Specify below**

REQUIRED EXPLANATION:

The prescriber may be required to submit medical records that support the medical necessity for the prescribed non-formulary drug. Standard timeframe for notice of decision is 72 hours.

EXPEDITED REQUESTS: Is this a clinically urgent situation? Yes No

A clinically urgent situation: a situation in which a delay in decision-making would seriously jeopardize the life or health of the member or would subject the member to severe pain that could not be adequately managed without the requested treatment. Please be aware, requests marked "expedited" which do not meet the aforescribed definition of a clinically urgent situation will be processed as nonurgent/regular priority.

DO NOT COMPLETE BELOW THIS LINE, FOR WELLMARK INTERNAL USE ONLY

Pharmacy/Medical Director Determination: Approve Deny

If Approved, Length of Approval: _____

Rationale for Approval/Denial: _____

Pharmacy/Medical Director Signature: _____ Date Signed: ____/____/____

Provider Notified of Decision: by letter by phone web portal Date: ____/____/____

Member Notified of Decision: by letter by phone Date: ____/____/____