

Exception to Coverage Request Complete Legibly to Expedite Processing

Date: Date: Patient Name: Patient Name: Prescriber NPI: Unique ID: Date of Birth: Prescriber Phone: Date of Birth: Prescriber Phone: Date of Birth: Prescriber Phone: Prescriber Fax: REQUEST TYPE: Quantity Limit Increase: New Drug* Quantity Limit Increase: New Drug* Quantity Limit Increase: Prescriber Fax: Quantity Limit Increase: New Drug* Quantity Limit Increase: Prescriber Fax: Quantity Limit Increase: New Drug* Quantity Limit Increase: Prescriber Phone: Prescriber Phone: Prescriber Phone: Prescriber Phone: Prescriber Phone: Prescriber Phone: Prescriber NPI: Prescriber Npie: Prescriber Phone: Prescriber Phone: Prescriber Phone: Prescriber Phone: Prescriber Prescriber Prescriber Phone: Prescriber Phone: Prescriber Phone: Prescriber Pres		Fax: 1-855-668-8551			
Patient Name: Unique ID: Date of Birth: REQUEST TYPE: Quantity Limit Increase¹ Gender-Specific² High Dose³	COMPLETE REC	QUIRED CRITERIA AND FAX	K TO: EPIPHANYR	X AT: 855-6 0	68-8551
Unique ID: Date of Birth: REQUEST TYPE: Quantity Limit Increase¹	Date:		Prescriber	Name:	
Date of Birth: Prescriber Fax: Quantity Limit Increase¹ Gender-Specific² High Dose³	Patient Name:		Prescribe	er NPI:	
Quantity Limit Increase Gender-Specific High Dose	Unique ID:		Prescriber F	Phone:	
New Drug4	Date of Birth:		Prescribe	er Fax:	
Quantity Limit Increase: Dose prescribed exceeds allowed quantity limits. Indicate diagnosis/clinical rationale why covered quantity and/or dosing are insufficient. See formularies at navitus.com for specific quantity limit restrictions. Gender-Specific Medications: Indicate diagnosis / clinical rationale for use. 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. New Drugs: Drug prescribed has not yet been reviewed by Navitus P&T Committee. For coverage consideration, a covered alternatives must be tried and failed or contraindicated. Complete the formulary alternatives table. Not Covered Drugs: All formulary alternatives must be tried and failed or contraindicated. Complete the formulary alternatives table. REQUESTED DRUG INFORMATION PREQUENCY QUANTITY If the drug requested is BRAND with an A-RATED GENERIC, an FDA MedWatch Form must be submitted. Access form at http://www.fda.gov/medwatch/getforms.htm and attach a completed copy to request. Formulary Max Dose Dosing Use Start-End Describe Specific and Significant	DEQUEST TV	☐ Quantity Limit In	crease ¹	r-Specific ²	☐ High Dose ³
Covered quantity and/or dosing are insufficient. See formularies at navitus.com for specific quantity limit restrictions. Gender-Specific Medications: Indicate diagnosis / clinical rationale for use. 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. New Drugs: Drug prescribed has not yet been reviewed by Navitus P&T Committee. For coverage consideration, a covered alternatives must be tried and failed or contraindicated. Complete the formulary alternatives table. Not Covered Drugs: All formulary alternatives must be tried and failed or contraindicated. Complete the formulary alternatives table. REQUESTED DRUG INFORMATION PRUG/DOSE* NDICATION / REASON FOR USE / CLINICAL RATIO DRUG/DOSE* NDICATION / REASON FOR USE / CLINICAL RATIO DRUG/DOSE* NDICATION / REASON FOR USE / CLINICAL RATIO DRUG/DOSE* NDICATION / REASON FOR USE / CLINICAL RATIO DRUG/DOSE* NDICATION / REASON FOR USE / CLINICAL RATIO DRUG/DOSE* NDICATION / REASON FOR USE / CLINICAL RATIO DRUG/DOSE* NDICATION / REASON FOR USE / CLINICAL RATIO DRUG/DOSE* NDICATION / REASON FOR USE / CLINICAL RATIO DRUG/DOSE* NDICATION / REASON FOR USE / CLINICAL RATIO DRUG/DOSE* NDICATION / REASON FOR USE / CLINICAL RATIO DRUG/DOSE* NDICATION / REASON FOR USE / CLINICAL RATIO DRUG/DOSE* NDICATION / REASON FOR USE / CLINICAL RATIO DRUG/DOSE* NDICATION / REASON FOR USE / CLINICAL RATIO DRUG/DOSE*	KEQUESTIT		rug⁴		lot Covered⁵
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** If complex medical management exists, supply supporting documentation with this request. If Approved, Coverage is granted for One Year	** If co	·			this request.
escriber Signature: Date:	escriber Sian	ature:			Date: