



Navitus Health Solutions  
 PO BOX 999  
 Appleton, WI 54912-0999  
 Customer Care: 1-866-333-2757

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**

<b>Date:</b>		<b>Prescriber Name:</b>	
<b>Patient Name:</b>		<b>Prescriber NPI:</b>	
<b>Unique ID:</b>		<b>Prescriber Phone:</b>	
<b>Date of Birth:</b>		<b>Prescriber Fax:</b>	

<b>REQUEST TYPE:</b>	<input type="checkbox"/> <b>Quantity Limit Increase<sup>1</sup></b>	<input type="checkbox"/> <b>Gender-Specific<sup>2</sup></b>	<input type="checkbox"/> <b>High Dose<sup>3</sup></b>
	<input type="checkbox"/> <b>New Drug<sup>4</sup></b>		<input type="checkbox"/> <b>Not Covered<sup>5</sup></b>

- <sup>1</sup> **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.
- <sup>2</sup> **Gender-Specific Medications:** Indicate diagnosis / clinical rationale for use.
- <sup>3</sup> **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.
- <sup>4</sup> **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.
- <sup>5</sup> **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
<b>DRUG/DOSE*</b>		
<b>INDICATION</b>		
<b>FREQUENCY</b>		
<b>QUANTITY</b>		

\* 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:** \_\_\_\_\_

Access Formularies via our Provider Portal [www.navitus.com](http://www.navitus.com) > Providers> Prescribers Login