

**Important:** Use this form when requesting coverage for all drugs covered under either the pharmacy or medical benefit.

Providers are **strongly encouraged** to submit this form and all chart documentation via the pharmacy provider portal. This will result in more reliable communication and expedited notification of determinations. Alternatively, if you are unable to access the portal, fax this form and all chart documentation to (217) 902-9798. If you have questions, please call (800) 481-1092, option 4.

**Urgent** means medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the patient's life/health, or the patient's ability to regain maximum function or in the opinion of the attending or consulting physician, would subject the patient to severe pain that could not be adequately managed without the requested care or treatment.

Section A – Member Information				
Today's Date:		First Name:		Last Name:
Member ID #:		Date of Birth:	Primary Insurance:	
Is this a <input type="checkbox"/> <b>new request</b> or <input type="checkbox"/> <b>a continuation of therapy</b> or <input type="checkbox"/> <b>a retrospective request for payment</b> ? Start date _____				
Were manufacturer samples provided? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If yes, quantity/days of supply _____				
Are the drugs being requested as part of a clinical trial? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If yes, list the clinical trial ID _____				
Is this patient currently hospitalized? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If yes, include the anticipated discharge date _____				
Section B – Requesting Provider Information				
First Name:		Last Name:		
Address:		City:	State:	Zip code:
Phone:	Fax:	NPI:		
Specialty:	Email:	Contact Name:		
Participating provider? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If no, do you have an approval to consult and treat? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> Auth # _____				
Section C – Rendering Provider Information for Medical Service Drugs (Buy-and-Bill)				
Is the rendering provider information the same as Section B? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If no, you must complete Section C				
Facility/Provider Name:				
Address:		City:	State:	Zip code:
Phone:	Fax:	NPI:		
Participating facility/provider? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> If no, do you have an approval to consult and treat? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> Auth # _____				
Section D – Drug Formulary Exception Requests ***Please include a supporting statement and chart documentation***				
Is this a request for any of the following exceptions to any formulary design? <input type="checkbox"/> <b>Yes*</b> <input type="checkbox"/> <b>No</b>				
<input type="checkbox"/> Non-formulary Exception – Coverage of a drug not currently listed on the formulary.				
<input type="checkbox"/> Quantity Exception – Coverage of a quantity of drug greater than the formulary limit.				
<input type="checkbox"/> Tiering Exception – Reduce the tier of a formulary drug (Specialty drugs are exempt).				
<input type="checkbox"/> Step-Therapy Exception – Request to bypass step therapy requirements.				
<input type="checkbox"/> Prior Authorization Exception – The drug-specific prior authorization criteria should not apply to your patient.				
Section E – Clinical Information of Drug(s) Requested ***Please include chart documentation***				
Drug Name & Strength	HCPCS	Qty/Days	Dose Per Administration/Directions for Use/Frequency of Administration	
ICD-10 code(s)			Procedure code(s)	
Additional information related to the request				
Section F – List All Previous Treatments ***Please include chart documentation***				
Drug Name/Therapy		Dates of Use	Reason for Failure	
<input type="checkbox"/> I certify that the information provided is true and accurate to the best of my knowledge.				
*The prescriber must submit a written supporting statement which explains why an exception is medically necessary.				
Prescriber's Signature _____			Date _____	