

Universal Pharmacy Medical Review Request Form

Only complete forms can be processed. Incomplete forms may result in an administrative denial due to lack of information

<p>PATIENT INFORMATION</p> <p>Name: _____ Date: _____</p> <p>DOB: _____ Member THP ID: _____</p> <p>Diagnosis: _____</p> <p>Relevant Co-morbid Diagnoses: _____</p> <p>Additional Comments: _____</p> <p>_____</p>	<p>PRESCRIBER INFORMATION</p> <p>Name: _____ Specialty: _____</p> <p>Provider ID: _____ Phone: _____</p> <p>Fax: _____ Office Contact: _____</p> <p>Prescriber Signature (required): _____</p>								
<p>REQUESTED DRUG INFORMATION</p> <p>Type of Program Override Request (circle one):</p> <table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">Dispensing Limitation</td> <td style="text-align: center;">Non-covered Drug</td> </tr> <tr> <td style="text-align: center;">Step Therapy</td> <td style="text-align: center;">Prior Authorization</td> </tr> </table> <p>Drug Name/Strength/Dosage Form: _____</p> <p>Duration of requested treatment: _____</p> <p>Reason for Coverage Request (check one):</p> <p>_____ Treatment failure (drug(s)): _____</p> <p>_____ Adverse reaction (drug(s)): _____</p> <p>_____ Other clinical reason(s): _____</p> <p>Duration of treatment with failed drug(s): _____</p>	Dispensing Limitation	Non-covered Drug	Step Therapy	Prior Authorization	<p>Tier exception request (Medicare Preferred ONLY): <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please specify reason(s) for request:</p> <p><input type="checkbox"/> Formulary/Preferred drug(s) contraindicated or tried and failed, or not as effective as requested drug</p> <p><input type="checkbox"/> Therapeutic failure or not as effective; please indicated length of therapy of each applicable drug and adverse outcome</p> <p><input type="checkbox"/> Other; please explain below</p> <p>Explanation: _____</p> <p>_____</p>				
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<p>Send/Fax completed forms to:</p> <p style="padding-left: 20px;">Tufts Health Plan Precertification Department 705 Mount Auburn Street Watertown, MA 02472 Fax: (617) 972-9409</p> <p style="text-align: center;">Drug List and Clinical Criteria available online at: www.tuftshealthplan.com</p>	<p>Antifungals (itraconazole (Sporanox), Penlac, terbinafine (Lamisil), etc.)</p> <p>Does the patient have uncomplicated onychomycosis? <input type="checkbox"/> Yes* <input type="checkbox"/> No</p> <ol style="list-style-type: none"> 1. Limited to nail surface? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Lunular involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Does the patient have a medical contraindication to oral antifungal therapy (Penlac only): <input type="checkbox"/> Yes (explain) _____ <input type="checkbox"/> No 4. Check all that apply: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Paronychia</td> <td><input type="checkbox"/> Diabetes Mellitus</td> </tr> <tr> <td><input type="checkbox"/> Systemic Fungus</td> <td><input type="checkbox"/> Immune Suppression</td> </tr> <tr> <td><input type="checkbox"/> Peripheral Vascular Disease</td> <td><input type="checkbox"/> None</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> Medically significant pain (Office notes required)</td> </tr> </table> <p><small>* Any request for coverage with a diagnosis of uncomplicated onychomycosis will be denied as a benefit exclusion</small></p>	<input type="checkbox"/> Paronychia	<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Systemic Fungus	<input type="checkbox"/> Immune Suppression	<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> None	<input type="checkbox"/> Medically significant pain (Office notes required)	
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