University of Arkansas
100% Copay Exception Medication Request Form

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Attn: Prior Authorization Department
10181 Scripps Gateway Court San Diego, CA 92131 Phone: 1-800-788-2949
Fax: 858-790-7100

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #

Instructions:
This form is to be used by participating physicians and providers to obtain coverage for a non-formulary drug for which there is no suitable alternative available. Please complete this form and fax to MedImpact Healthcare Systems, Inc. at (858) 790-7100 or please call (800) 788-2949 with this information. If you have any questions regarding this process, please contact MedImpact's Customer Service at (800) 788-2949.

☐ **REQUEST FOR EXPEDITED (URGENT) REVIEW:** BY CHECKING THIS BOX, I CERTIFY THAT APPLYING THE STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Medication Request Information (please complete each section of this form prior to transmittal): *Denotes Required Fields

PATIENT INFORMATION		**PHYSICIAN INFORMATION**	
*Name:		*Name:	
*ID#:		*Specialty:	
*Date of Birth:		ID# / DEA#:	
*Health Plan:		*Phone: ( ) -	*Fax: ( ) -
*Diagnosis (ICD-10 Code, if known):			
REQUESTED DRUG INFORMATION		**PHARMACY INFORMATION**	
Drug Prescribed:		Name:	
Dose:	Strength:	Phone: ( ) -	Fax: ( ) -
Quantity Prescribed:	Directions:	Length of Treatment: (Please be specific.)	

ALTERNATIVE DRUG INFORMATION		**ADVERSE REACTION, CONTRAINDICATION, OR FAILURE**	
Drug:		Incident:	
Dose:	Strength:	Dates of Therapy:	
Quantity Prescribed:	Directions:	Length of Treatment: (Please be specific.)	

ALTERNATIVE DRUG INFORMATION		**ADVERSE REACTION, CONTRAINDICATION, OR FAILURE**	
Drug:		Incident:	
Dose:	Strength:	Dates of Therapy:	
Quantity Prescribed:	Directions:	Length of Treatment: (Please be specific.)	

Reason for Medication Request (Please be specific, give detail.):

1. Are there formulary alternative(s)? ..... ❑ Yes ❑ No
2. Have all formulary alternatives been tried? ..... ❑ Yes ❑ No
3. Is there a contraindication to the alternative medications available? ..... ❑ Yes ❑ No
4. Are chart notes provided documenting a 3 month trial and failure of ALL formulary alternatives? ... ❑ Yes ❑ No
5. Are chart notes provided and a completed MedWatch form provided documenting adverse reaction to ALL formulary alternatives? ..... ❑ Yes ❑ No

Please submit or document any additional information.

Revised: 5/17