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**		
Date:		**Prescriber Name:**	
Patient Name:		**Prescriber NPI:**	
Unique ID:		**Prescriber Phone:**	
Date of Birth:		**Prescriber Fax:**	

REQUEST TYPE:	☐ **Quantity Limit Increase[1]**	☐ **Gender-Specific[2]**	☐ **High Dose[3]**
	☐ **New Drug[4]**	☐ **Not Covered[5]**	

[1] **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.

[2] **Gender-Specific Medications:** Indicate diagnosis / clinical rationale for use.

[3] **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.

[4] **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.

[5] **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**
DRUG/DOSE*		
INDICATION		
FREQUENCY		
QUANTITY		

* 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 > Providers> Prescribers Login