MINNESOTA UNIFORM FORM FOR PRESCRIPTION DRUG PRIOR AUTHORIZATION (PA) REQUESTS AND FORMULARY EXCEPTIONS

INSTRUCTIONS

Important: Please read all instructions and information before completing the form.

Please do NOT send this form to a patient's employer or to the Minnesota Department of Health (MDH) or to the Minnesota Administrative Uniformity Committee (AUC).

Note: This version of the form (C-2.0) is current as of October 2015, and supersedes previous versions of Minnesota Department of Health forms for PA requests and formulary exceptions.

This form will not change frequently. The form version number and most recent revision date are displayed in the lower right corner.

Overview:

The following form is made available by the Minnesota Department of Health (MDH) pursuant to statute, to facilitate exchanges of information between prescribers and patients' insurance carriers, HMOs, Pharmacy Benefits Managers (PBMs), or other payers* of prescription drug claims.

Intended use and requirements:

The form is intended primarily for use by prescribers, or those designated and authorized to act on behalf of prescribers, to:

1. **Request an exception to a prescription drug formulary.**

   - Requests for formulary exceptions are requests to make nonformulary prescription drugs available to a patient as a formulary drug.
     - Minnesota Statutes, section 62J.497, Subd. 4 requires that all health care providers must submit requests for formulary exceptions using the uniform form, and that all payers must accept this form from health care providers. No later than January 1, 2011, the uniform formulary exception form must be accessible and submitted by health care providers, and accepted and processed by group purchasers, through secure electronic transmissions. Note: A previous restriction in law that facsimile was not considered "secure electronic transmission" was removed in 2010.

2. **Request a prior authorization (PA) for a prescription drug.**

   - Prescription drug prior authorization requests are requests for pre-approval from a payer for specified medications or quantities of medications.
     - Minnesota Statutes, section 62J.497, subd. 5 requires that by January 1, 2016, drug PA requests must be accessible and submitted by health care providers, and accepted by payers, electronically using the NCPDP SCRIPT Standard version 2013101.

Additional Instructions:

- Prescribers, or their designees, use parts A-F as applicable. Payers making the form available on their websites may pre-populate section A. Payers use section G when responding to requests.
- Payers may request additional information or clarification needed to process formulary exceptions and PA requests.
- Payers may supply additional instructions or other relevant or legally required information with their response.
- **Complete section F when submitting prescription drug PA requests to the Minnesota Department of Human Services.**

* Note: The term "payers" is used to avoid possible confusion. The electronic submission and acceptance requirements of Minnesota Statutes § 62J.497, subd. 4 and 5, apply to "group purchasers". The term "group purchaser" is defined in Minnesota Statutes § 62J.03, subd. 6 and can be considered more commonly as "payer".

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See additional instructions and overview, Instructions page.

Please check the appropriate box below. This form is being used for:

☐ **Formulary Exception** ☐ **Prior Authorization (PA) Request** ☐ **Unsure/Unknown**

A | Destination This form is being submitted to: (Payers making this form available on their websites may pre-populate section A.)

Payer Name: MedImpact

Payer Contact Name (IF AVAILABLE):

Payer Address: 10181 Scripps Gateway Court

City, State, Zip: San Diego, CA 92131

Payer Phone: 1-800-788-2949

Secure Fax: 858-790-7100

Other:

B | Patient Information

When filling Patient Health Plan ID number below, please note: If the patient has prescription benefits that are separate or "carved out" from the health plan benefits, provide the patient's prescription benefit card ID number (the "cardholder ID"). If the patient's prescription benefits are integrated with the health plan coverage (if there is no separate prescription benefit ID number), provide the patient's health plan ID number.

Patient Name (LAST, FIRST, MI):

DOB:

Gender:

Patient Address:

City, State, Zip:

Health Plan or Prescription Plan:

Patient Health Plan ID Number:

(OR PRESCRIPTION PLAN ID IF DIFFERENT THAN HEALTH PLAN ID)

C | Prescriber Information

Prescriber Name (LAST, FIRST, MI):

NPI:

Specialty:

Prescriber Business Address:

City, State, Zip:

Health Plan or Prescription Plan:

Patient Health Plan ID Number:

Prescriber Phone:

Prescriber Secure Fax:

Prescriber Point of Contact (POC) Name:

(IF DIFFERENT THAN PRESCRIBER)

POC Phone:

(IF DIFFERENT THAN PRESCRIBER)

POC Secure Fax:

Clinic/Location/Facility Name:

Clinic/Location/Facility Contact Name:

Clinic/Location/Facility Phone:

Secure Clinic/Location/Facility Fax:

Clinic/Location/Facility Address:

City, State, Zip:

"X" DEA number (buprenorphine prescriber status number, always preceded by "x," issued per the Drug Addiction Treatment Act of 2000 (Data 2000)):

D | Prescription Drug Information (Medication information)

When completing this section and the following section (E), medication "strength" is usually expressed in milligrams, e.g., 30mg, 15mg/ml, etc. Medication "dosing schedule" is used to report how often the patient will take/use the medication, e.g, daily, four times per day, every four hours, as needed, etc. If request is for a Minnesota Department of Human Services recipient, please also fill out Section F.

Drug Being Requested:

(REQUESTED DRUG NAME)

Strength:

(E.G., 30 MG, 15 MG/ML, ETC)

Dosing Schedule:

Date Therapy Initiated:

Duration of Therapy Expected:

Authorization Start Date:

Clinical Drug Trial Request?

(NOTE: THE MINNESOTA DEPT. OF HUMAN SERVICES DOES NOT COVER CLINICAL DRUG TRIALS)

Is Dispense as Written (DAW) Specified?

Rationale for DAW?

Is patient currently being treated with the drug requested?

Date Started:

E | Patient Clinical Information

Diagnosis Related to Medication Request: _____

Drug Allergies: _____ (IF RELEVANT TO THIS REQUEST)

Height: _____ (IF RELEVANT TO THIS REQUEST)

Weight: _____ (IF RELEVANT TO THIS REQUEST)

PREVIOUS THERAPIES TRIED / FAILED (list name, date prescribed, etc., in boxes below. Note: Medication "strength" is usually expressed in milligrams, e.g., 30 mg, 15 mg/ml, etc. Medication "dosing schedule" is used to report how often the patient will take/use the medication, e.g., daily, four times per day, every four hours, as needed, etc.):

Drug Name	Strength	Dosing Schedule	Date Prescribed	Date Stopped	Describe Adverse Reaction or Efficacy Failure

RATIONALE FOR REQUEST (and also include any additional pertinent clinical information/comments regarding rationale:

F | Pharmacy Information

Pharmacy Name: _____ NPI: _____ Pharmacy Phone: _____

Pharmacy Address: _____ City, State, Zip: _____

NDC Number for Prescription Drug Being Requested: _____ Pharmacy Fax: _____

G | Request Determination (may be completed by payers and sent to providers)

Date Request Received by Payer: _____ Date of Decision: _____

Payer Responder/Contact Name: _____ Payer Respondent/Contact Phone: _____

Payer Respondent/Contact Email: _____ Request Approved/Denied: _____

Pharmacy Authorization/Reference Number: _____ (IF APPLICABLE TO PAYER)

Comments Regarding Decision: (INCLUDE EFFECTIVE AND END DATES OF DECISION IF APPLICABLE)

Additional Information or Instructions

Note: Group purchasers may supply additional instructions or other relevant or legally required information with their response. Examples of additional information might include: Appeals rights and processes; other notifications; other information required for legal or clarification purposes.

CONFIDENTIALITY NOTICE: The information in this form is confidential and intended for the use of the recipient. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance of the contents of this communication is strictly prohibited. If you have received this form in error please immediately notify the sender to arrange for its return. Thank you for your assistance.