Health Options
Highmark Blue Cross Blue Shield Delaware

MEDICAID DRUG EXCEPTION FORM

If you are requesting a drug that requires a prior authorization or step therapy, please complete the DRUG SPECIFIC PRIOR AUTHORIZATION or STEP THERAPY FORM found on the website at http://www.HighmarkHealthOptions.com. If you need to speak to a Pharmacy Services Representative, **call 1-844-325-6253** Monday through Friday 8:30 a.m. to 4:30 p.m.

FAX COMPLETED FORM TO: 1-855-476-4158

SECTION A MEMBER INFORMATION			
First name:	**Last name:**	**Date of Birth:**	**Member ID:**
Allergies:	**Type of reaction(s):**		

SECTION B PHARMACY INFORMATION	
Pharmacy Name:	**Pharmacy Phone Number:**

SECTION C CLINICAL INFORMATION			
Drug Name Requested:	**Dosage and Frequency:**	**Quantity:**	**Length of therapy:**
Diagnosis for which drug is being requested:			
You must be able to document the therapeutic failure or contraindication to formulary products for a request to be approved.			

PDL/FORMULARY ALTERNATIVES THAT HAVE BEEN USED BY THE PATIENT		
Drug Name/ Strength	**Dates Tried:**	**Reason therapy failed or discontinued**
Is member currently or recently hospitalized? **Yes** ☐ **No** ☐		**Date of Discharge:**
Additional Clinical or Supporting Information: ***Please include office notes, lab data, and other supporting medical literature.***		

SECTION D PRESCRIBER INFORMATION				
Prescriber Name (printed):		**Prescriber Specialty:**		**NPI Number:**
Office Phone:	**Contact Person:**	**Extension:**	**Office Fax:**	
Prescriber Signature:		**Date:**		

If the request is denied, the prescriber can change the prescription to an appropriate formulary alternative or with written member consent file an appeal with Health Options. The Drug Formulary is available on the website at http://www.HighmarkHealthOptions.com

Revised 10/2014 **May Photocopy for Office Use**

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