

COMMERCIAL MEDICATION EXCEPTION REQUEST FORM 2017

Date of Submission: _____



For a complete list of list of all medications that require a prior authorization, please visit AvMed' website at <https://www.avmed.org/web/guest/preferred-medication-lists>

- For medications administered in the in the physician's office, participating facility or in the home by a healthcare practitioner please select the "[PA Requirements – Office, Facility, Home Health](#)" link
- For medication obtained at the pharmacy please select the appropriate formulary based on the member's enrollment.

PATIENT INFORMATION

Member ID	A	Date of Birth		Is Member Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
Member Name		Height		Weight
Diagnosis		Diagnosis (ICD-10) Code		

DELIVERY – ADMINISTRATION INFORMATION

<input type="checkbox"/> In-office (MD to supply and administer) <input type="checkbox"/> Retail pharmacy Pickup <input type="checkbox"/> Home Health Provider	If you are requesting medication delivery to your office, enrollment in the CVS Specialty Medication Delivery Program is required. Please choose below: <input type="checkbox"/> CVS Specialty – Patient delivery (self-administered specialty meds) <input type="checkbox"/> CVS Specialty – MD office delivery <i>CVS Specialty can be reached at : Phone: 866-638-8311 Fax:800-323-2445</i>
<input type="checkbox"/> Outpatient Facility <input type="checkbox"/> Infusion Suite Name of Facility/Suite: _____ Facility/Suite Provider Number: _____	

ADDITIONAL MEDICATION INFORMATION

FAX 877-535-1391

Please attach all Office Notes and Current Lab Results

Incomplete forms and/or inadequate documentation may result in a denial

Drug Name		Quantity	
Directions for Use		<input type="checkbox"/> New Therapy	<input type="checkbox"/> Continuation of Therapy
If Continuation of Therapy, indicate the member's therapeutic response:			
Duration of Therapy		Procedure Code	
Reason for Request			

PHYSICIAN INFORMATION

Prescriber Name		Prescriber Specialty	
Form Completed By		AvMed Provider Id #	
NPI #		Office Number	Ext
Contact Name		Fax Number	

Please remember to review and complete all fields on this form and include appropriate Office Notes and Labs with all requests

Fax completed form to AvMed at 1-877-535-1391