

Health New England
Medication Request Form (MRF)

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage for Quantity Limit Exceptions, Step Therapy Exceptions, Multisource Brand Exceptions (brand-name multiple-source drugs that have an FDA "AB"-rated generic equivalent), and New-To-Market drugs. Complete this form and fax to Health New England at 413-233-2777, please allow 3-15 days to process. If you have any questions regarding this process, contact Health New England Member Services Department at (800) 310-2835.

Medication Request Information (please complete applicable section of this form prior to transmittal)

Please complete all Patient information, Physician information and Drug information

Patient Information (all required):

Physician Information

Patient Name:	Physician Name:	
Patient HNE ID#:	Specialty:	
Patient Date of Birth:	Contact Name:	
Allergies:	NPI #:	
Diagnosis:	HNE Provider #:	
Co-morbid conditions which may be relevant:	Area Code and Telephone #: () -	
	Area Code and Fax # (required): () -	
	Start Date	End Date/Length of Treatment

Drug Information

Current Generic Drug:	Requested Drug name:
Dose/Strength (please be specific):	Frequency per day:
Dosage form (Tablet, Capsule or Injection etc.):	Quantity per month:
Physician signature:	Date:

Please complete one of the options below

QUANTITY LIMIT EXCEPTION	STEP THERAPY EXCEPTION*
Reasons for exceeding limit: _____ _____ _____	<input type="checkbox"/> Patient has filled a prescription and tried a step 1 (generic) drug in the previous 180 days. THIS EXCLUDES THE USE OF SAMPLES. First line drug(s) tried: _____ Dates Tried: _____
MULTISOURCE BRAND EXCEPTION	Why treatment failed: _____
<input type="checkbox"/> Received samples of Brand Name drug from provider	NEW-TO-MARKET
<input type="checkbox"/> Inadequate response to generic: _____ _____ _____	Other failed FDA approved treatments for this condition: _____ Reasons for waiving clinical review period: _____
<input type="checkbox"/> Documented allergic reaction to generic formulation: _____ _____ _____	*For Commercial HNE Members an approval will result in a copay of \$50 or 50% of the price of the drug-whichever is greater.

Other pertinent history: _____

*If this request is for a statin please provide the current LDL and goal: _____