

**Health New England
Medication Request Form (MRF)**

Step Therapy Exception

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

**Please Fax to
413-233-2777**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of medications which have not met the first line for step therapy. Please complete this form and fax to Health New England at 413-233-2777 and please allow 3-15 days to process. If you have any questions regarding this process, please contact Health New England Member Services Department at (800) 310-2835.

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

Patient Information (all required)		Physician Information (all required)	
Patient Name:		Physician Name:	
		Specialty:	
		NPI #:	
Patient HNE ID#:		HNE Provider #:	
Patient Date of Birth:		DEA #:	
Allergies:		Area Code and Telephone #: () -	
Diagnosis:		Area Code and Fax # (required): () -	

Drug Information (all required)

Requested Drug (name and strength):

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

Start Date:	End date or length of Treatment:
Dose (please be specific):	Frequency per day:
Dosage form (if not oral)	Quantity per day or month: (circle appropriate time frame)

Indication: (list primary diagnosis and any co-morbid conditions which may be relevant.)

Documentation of Medical Necessity (check all that apply):

Patient has tried a step 1 (generic) drug in the previous 180 days and has documentation. THIS IS EXCLUDING THE USE OF SAMPLES of a step 1 or step 2 medication.

You must complete all of the following:

<input type="checkbox"/> First line drug tried:	<input type="checkbox"/> Length of treatment:
<input type="checkbox"/> Dates tried:	<input type="checkbox"/> Why treatment failed:

If the patient has not filled a prescription for a first line drug in the previous 180 days, please indicate the clinical justification for 2nd line drug and explanation of medical necessity:

Other pertinent history: _____