



Dean Health Plan
 1277 Deming Way
 Madison, WI 53717
 1-800-279-1301
 Fax: 1-920-735-5350

Exception to Coverage Request
 Allow 7 Days for Processing
 Complete Legibly to Expedite Processing

COMPLETE REQUIRED CRITERIA AND FAX TO: NAVITUS HEALTH SOLUTIONS 920-735-5350

Date:		Prescriber Name:	
Patient Name:		Prescriber NPI:	
Unique ID:		Prescriber Phone:	
Date of Birth:		Prescriber Fax:	

REQUEST TYPE:	<input type="checkbox"/> Quantity Limit Increase¹	<input type="checkbox"/> Gender-Specific²	<input type="checkbox"/> High Dose³
	<input type="checkbox"/> New Drug⁴	<input type="checkbox"/> Not Covered⁵	

- ¹ **Quantity Limit Increase:** Dose prescribed exceeds allowed quantity limits. Indicate diagnosis/clinical rationale why the covered quantity and/or dosing are insufficient. See formularies at navitus.com for specific quantity limit restrictions.
- ² **Gender-Specific Medications:** Indicate diagnosis / clinical rationale for use.
- ³ **High Dose Alert:** Dose prescribed is flagged as >2.5 times the recommended maximum daily dose. Please provide monitoring criteria and/or clinical rationale for use of high dose.
- ⁴ **New Drugs:** Drug prescribed has not yet been reviewed by Navitus P&T Committee. For coverage consideration, all covered alternatives must be tried and failed or contraindicated. Complete the formulary alternatives table.
- ⁵ **Not Covered Drugs:** All formulary alternatives must be tried and failed or contraindicated. Complete the formulary alternatives table.

REQUESTED DRUG INFORMATION		INDICATION / REASON FOR USE / CLINICAL RATIONALE
DRUG*		
STRENGTH		
FREQUENCY		
QUANTITY		

* If the drug requested is **BRAND** with an **A-RATED GENERIC**, an FDA MedWatch Form **must** be submitted. Access the form at <http://www.fda.gov/medwatch/getforms.htm> and attach a completed copy to request.

Formulary Alternative(S)	Max Dose Used	Dosing Frequency	Use Start-End Dates	Describe Specific And Significant Side Effects and/or Ineffectiveness

** If complex medical management exists, supply supporting documentation with this request.

If Approved, Coverage is Granted for One Year

Prescriber Signature: _____ **Date:** _____